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HOSPITAL
GAZETTE

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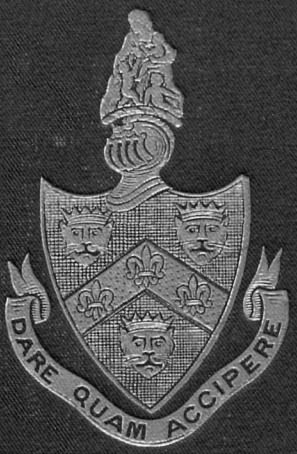
VOL. 33

1919.



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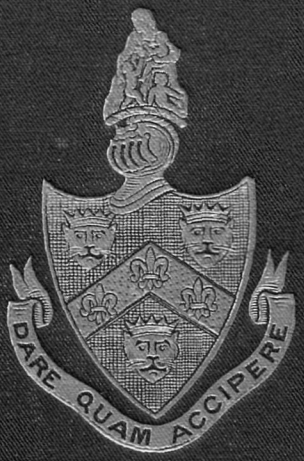
Guy's Hospital Gazette.



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Passim.

THIS being our first appearance in the New Year we take this opportunity of wishing all who read these lines, whether under foreign skies or here in London, the Happiest of New Years.

For the past four years amid all the suffering and with the future one continuous strain of anxiety, this, our Editorial wish, has assumed a very real significance, though it has been uttered with a certain hesitation, and a certain distant respect for the future and all that it might bring forth. To shout of happy times from the house-tops in the very midst of the struggle seemed to jar, and a "prosperous New Year" was in no sense an accurate expression of our New Year's Greetings. Now all that has changed, the keynote is victory, and joyfully and sincerely we send forth the old wish to all and sundry, for whatever have been the sorrows in the past, for the moment all eyes are on the future, and it is a fascinating gaze. The prospects are unique. Never has a New Year opened with so much to be reconstructed and so many problems to be solved, and in this the medical profession must play a big part. The experience through which the country has passed has enlarged its sense of what is possible, and certain it is that the demands of the public from medicine will far exceed anything that has yet been known. But we must turn from that gaze. Therein is material for many an article in our pages, and far be it from us to trespass on the domain of our contributors.

THE first Christmas of Peace has passed, and at Guy's it has been celebrated with an enthusiasm well worthy not only of the old traditions of the Hospital, but of the consciousness of triumph, which has naturally been the background of all the joyful celebrations of this mid-winter festival.

IT may be our part to chronicle the hard facts, but we have none, only vivid memories of a week crowded with excitement linger and pursue us into the normal duties of Hospital life which have long been resumed.

THERE were the busy days of preparation in which both nurses and men displayed untiring energy in hoisting the decorations, those fruits of much silent labour, which included not only lamp-shades in their countless variety of form and colour, but in some cases hand paintings and stencil work. The party of carol singers which went round from ward to ward was greatly appreciated by both patients and de-

corators. By Christmas morning all wards were ready and eager for the "Niggers," which form the prelude, as it were, of many festivities to follow.

Led by the big drum they marched forth from the College, weird and wonderful looking objects, to be photographed on the Colonnade steps; and was not Sir Cooper Perry of their number? All wards and Out-Patients were visited as usual. Many of the songs were topical; Massa Warwick seemed to be full of "hits," which he dealt out unmercifully in his own wards. Massa Debenham in a hoarse whisper told the nurses what was not written in "Ashdown," and together with Massa Bonar urged all and sundry to bathe in the Surpentine. The comic soldiers' duet (Massas Lyne and Brown) "Après la Guerre" was a great favourite, and, of course, "Sir Coo" always brought roars of applause. "Reggie," in spite of having never practised his songs, sang with much feeling and invariably brought down the house when he asked who was the sugar controller. The W.A.A.C.'s were most unladylike, but this was made up for by the extreme gentleness of the baboon (Massa Cutts), who delighted the audience by nursing the tiniest babies. Massa Siggs accompanied throughout in magnificent style.

Massa Van sang well when he remembered the words and Massa Cellier when he didn't. The Hun narrowly escaped with his life from the furious onslaughts of the boys in Out-Patients, and finally Massa Johnson led his tired troop out of Astley Cooper after a most strenuous and enjoyable day. All agreed that the Niggers had given a thundering good show and had given Christmas a splendid start off.

THE whole week following is a confused memory of concerts, teas, and the perpetual hauling of chairs, until the end of the Astley Concert, when one thing is clear in our memory—and that is, the bon-fire which heralded the New Year. Few of the present generation of students have witnessed this old custom, but as the Old Year went up in smoke, the President of the Residents, garbed in a nurse's cloak, climbed on to the Founder's statue, and the circular dance began. "Auld Lang Syne" struggled to be heard above the roaring of the fire, but soon the old Nigger choruses were in evidence. Finally, the crowd surged to Sir Cooper Perry's house, giving three cheers for him; then over to the Matron's Residence, with more cheers, and final cheers for 1919, the New Year of Peace.

ALL Guy's men will join with us in welcoming back into the corporate life of the Hospital the following, whose absence has been sorely felt:—Mr. P. Turner and Mr. L. Bromley as Assistant Surgeons. The latter resumes the post of Dean of the Medical School, the burden of which has been borne by Dr. Pembrey during these difficult years. Dr. H. W. Barber, who resumes as Medical Registrar, and Messrs. E. G. Schlesinger and G. T. Mullally as Surgical Registrars. Guy's is singularly fortunate in starting the New Year with such valuable additions to its Teaching Staff.

WE heartily congratulate Colonel W. Hale White, M.D., R.A.M.C., on the honour recently conferred upon him of the award of Knight Commander of the Order of the British Empire for services rendered in connection with the war.

We would draw attention of all Guy's men, especially, perhaps, all those who have just entered the Medical Wards, to Col. Hale White's interesting article on the Teaching of Medicine which appeared in the *Lancet* of January 4th. Many will note with interest the commentary on the "prevailing system of examinations."

With regard to our last issue—the War Memorial Number—certain corrections have already been received, and we repeat our request of last time that all who know of any mistakes or omissions should point them out with the least possible delay, in order that the revised issue in March may be as free from inaccuracies as possible. Two letters have been received containing the suggestion that ultimately a complete record of the fallen should be published under a separate binding. Lt.-Col. A. F. Hurst, whose letter we publish, goes further, and would like the complete list of Guy's men who have served. We think there is much to be said in favour of this suggestion, which is being considered by the War Memorial Committee. In our next issue we hope to be able to make a statement which will completely meet the wishes of Lt.-Col. Hurst.

Two errors demand immediate correction, and we are only too happy to publish them. They are the names of C. A. R. Gatley and P. J. Monaghan which erroneously appeared in the list of fallen. Gatley has been wounded, but both are alive. For our part, we offer our humblest apologies, at the same time feeling sure that they, out of gratitude for their timely deliverance, will straightway double their subscriptions to the War Memorial.

FURTHER SUBSCRIPTIONS TO JAN. 9TH.

	£	s.	d.
Brought forward	2,148	3	2
A. H. Spicer	5	0	0
W. M. Mollison (first instalment of £50) ...	10	0	0
J. V. Salvage	1	1	0
Mrs. M. Martin	1	1	0
F. E. Rudd	1	1	0
J. Evans	1	1	0
R. Wynne Rouw	25	0	0
A. H. Staples	1	1	0
W. W. Leigh	5	5	0
E. Biddle	2	2	0
E. A. Tomes	10	0	0
F. Wallace Wilson	10	10	0
A. Payne	2	2	0
J. Alison Glover	1	1	0
A. Alcock	5	5	0
F. D. Lumley	1	1	0
F. Beard	2	2	0
H. J. Hobey	2	2	0
H. N. Purdom	3	3	0
J. L. Perceval	2	2	0
W. H. Fisher	5	5	0
—. Curtis-Hayward	2	2	0
Morgan Lloyd	2	2	0
H. Lucas	3	3	0
F. H. Parker	1	1	0
G. O. Betts	2	2	0
D. G. Greenfield	10	10	0
T. Reuel Atkinson	5	5	0
A. Withers-Green	1	1	0
H. M. M. Woodward	2	2	0
F. J. Steward	50	0	0
A. Percy Allan	2	2	0
Stanley Wickenden	1	1	0
	£2,327	19	2

CORRECTIONS TO LIST PUBLISHED ON DEC. 28TH, 1918.

	£	s.	d.		£	s.	d.
J. W. H. Eyre ...	10	0	0	first instal. of	50	0	0
W. A. Bulleid ...	5	5	0	" "	26	5	0
Sir Cameron Gull...	10	0	0	" "	50	0	0
G. Poock ...	3	6	8	" "	10	0	0
A. W. Ormond ...	26	5	0	" "	52	10	0
H. Spon ..	10	10	0	" "	52	10	0
W. T. Milton ...	1	1	0	" "	5	5	0

The present issue of the Gazette opens a new volume—the thirty-third. An index and title pages for last year's volume will shortly be prepared, and readers who wish to have their sets bound should send them to the Librarian. We would also remind our readers that the Annual Subscription of 12s. 6d. to the Hospital Gazette and Reports is now due, and should be made payable to the Manager, Gazette Office, Guy's Hospital, at the earliest opportunity.

In an account of the Hospital and Medical School during the War in our last issue there appeared the history of the Officers' Section, how it came into being, and how it was run. That the authorities have not been unmindful of the services of the Hospital in this direction was shown by the award of the Royal Red Cross to Sister Stephen some two years

ago. We gladly publish in another page a letter signed by the D.D.M.S. London District conveying appreciation and thanks for the work carried on in Officers' Section during the war, so that all who contributed in any degree to the success of the ward may know how much their labour and devotion has been appreciated. It has taken a prominent part in the services Guy's has been privileged to render to the common cause. Stephen Ward will forthwith become available again as a medical ward.

THE daily press has lately been recording a considerable amount of widespread dissatisfaction with the way demobilisation is being carried on. It is, therefore, gratifying to learn that in one direction at least the opinion of the Government is clear and unmistaken. Teachers and students of medicine are entitled to immediate release, as is shown by the following letter :—

Copy of letter received from the War Office—

20th Deecmber, 1918.

Sir,

I am directed to inform you that it has been decided that all Teachers, Students, and Inspectors of Schools may now, if they so wish, be released from military service, for the purpose of resuming their scholastic avocations.

I am, therefore, to say that such gentlemen as may inquire of you how their release may be obtained should be directed themselves to make application to their respective Commanding Officers.

I am, Sir,
Your obedient Servant,
M. EARLE, Colonel,
for Director of Staff Duties.

To Vice-Chancellors of Universities and Headmasters of Schools furnishing Contingents of the Officers Training Corps.

We understand, however, that while in some cases the release is almost immediate, in others there is considerable delay. The cause of this delay appears to be the necessity of obtaining the sanction of individual commanding officers. We are of opinion that this should not be allowed to influence the decision, for it is too often the case that commanding officers, losing sight of the economic needs of the country, consider the interests of their own unit before the principles embodied in the central scheme of demobilisation.

AMONGST the recently repatriated officers from Turkey we are glad to see the name of Capt. A. C. M. Coxon, 5th Norfolks, who was taken prisoner during the Gallipoli Campaign in 1915. We shall look forward to his early return to Hospital.

THIS was handed by a small girl to Sister Surgery—

Please Nuse will you Please hand this to the Doch.

Mrs. Anderson,
No. 18,
Gilliams Court,
Paridise Street,
Rotherhithe.

Please Doctor I am sending my child as I cannot come myself as I have queer eyes And she is been bad sence Sunday And is broke out all over the Body Legs and aslo face and feet and will you axemanion her and Let me know if she is to go to school they Broke out like waterier Blister and that out they have turn Doctor only she have to go to school.

AMONGST a package of articles of clothing received at Christmas by one of the Ward Sisters was an undergarment inside which was pinned the text, "Abide in me, and I in you."

Obituary.

JOHN C. ROBERTSON.

John C. Robertson was born in Selkirk (Scotland). He came to London with his family when he was about 5 years of age. His first school was a ladies' one, and after attending that for about six months he went to Balham High School for a few years. From there he went to Dunheved College, Launceston, was there for four and a half to five years, finishing there, and in 1912 he went straight to Guy's Hospital as dental and medical student (joint course).

He had just finished his two years in the Dental Mechanical Department and had passed his First Professional Examination in September, 1914. The day after he knew the result, he, along with others, joined as private the 4th Cameron Highlanders about the end of September, 1914, at Bedford, where he was trained.

He remained at Bedford until February, 1915, and although he had his papers ready for a commission, he, along with several of his friends, when they got the order to go to the Front, destroyed his commission papers, preferring to go out as an ordinary private. They landed in France, and within seven days were in the trenches. He went through the battle of Neuve Chapelle unscathed, but at the battle of Festubert, on the morning of the 17th May, 1915, he fell wounded, and from that day to this nothing has been heard of him. He has disappeared absolutely and entirely, and thus a young and promising life, of high character, was ended.

Pass List.

University of Oxford.

SECOND M.B.

At the recent Examination, H. M. MacKeith was approved in Materia Medica and Pharmacy.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES.

At the recent Examination the following were successful:—W. G. Booth, N. W. MacKeith, H. J. W. J. Westlake.

SECOND EXAMINATION FOR MEDICAL DEGREES.

PART I.

At the last Examination the following candidates were successful:—S. C. Bakhle, C. K. Colwill, B. L. Laver, *M. MacKenzie.

*Awarded a mark of distinction.

Society of Apothecaries of London.

At the last Examination, S. H. Robinson passed in Surgery (Sec. I).

Change of Address.

Capt. T. E. Ashdown Carr, R.A.M.C., from Kriegsgefangenen Lazaratt, Langensalza, Germany, to 9, Carlton Terrace, Blackpool.

Surg. Sub-Lieut. E. T. Lloyd, from H.M.S. *Afridi*, to Guy's Hospital.

Surg. Sub-Lieut. B. M. Tonkin, from H.M.S. *Hydra*, to Guy's Hospital.

Philip Turner, M.S., from No. 3 General Hospital, B.E.F., to 73, Wimpole Street, W. 1.

Capt. J. A. Ryle, R.A.M.C.(S.R.) from Field Ambulance, B.E.F., to 17, Albert Palace Mansions, Battersea Park, S.W.

Suggestions for the Teaching of Preventive Medicine.

BY R. KING BROWN, M.D.

THE following remarks on the subject of preventive medicine were prompted by a chance conversation with a general practitioner on the subject of a certain disease about which we were both interested and desired more information. Involuntarily each of us sought this on our own lines, my friend inquiring about the treatment and I inquiring about the prevention, and it apparently struck him for the first time that I looked on disease from a totally different angle of view from the general practitioner, and this remark it was which set me thinking on the subject.

My ideas, however, did not take definite shape till I read Sir George Newman's "Notes on Medical Education," and was called upon to assist in revising the medical curriculum at Guy's Hospital with a view among other reforms of bringing the subject of preventive medicine into greater prominence.

While the great war did not by any means originate the subjects of preventive medicine and hygiene, it has shown how the intelligent application of their principles to the armies at home and abroad have practically abolished or greatly reduced the prevalence of many diseases which formerly decimated them. I need only mention typhoid fever and tetanus. It is thought, therefore, that what was accomplished in the army might be accomplished among the civil population, but on a much larger scale, and instead of fixing our attention on a few infectious and epidemic diseases we might apply the principles of hygiene and prevention to *all* the diseases to which flesh is heir.

To many this will seem a well-nigh impossible task and require more or less of a revolution in the teaching of medicine, but just as the "centre of gravity" or the "angle of view" in medicine has shifted as this science has progressed, I am hoping that they will come round to the preventive view which, in my opinion, can take place without acting detrimentally, but rather otherwise, on the curative aspect.

Historically, one might describe the evolution of medicine as exhibiting three stages which one might designate as the "centres of gravity," viz.: (1) the empirical stage, (2) the pathological stage, and (3) the physiological stage. The first extends from the earliest records of scientific medicine and ended somewhere about Harvey's discovery. The second stage we are in at present, and the third is just commencing. Each stage has overlapped considerably the preceding one, and while the latter recedes somewhat into the background, it does not necessarily mean that it is forgotten or neglected, but that it has assumed its proper position in the general scheme of medical science and has given way to the more important angle of view of the next succeeding stage. Now this applies to the physiological stage, which is synonymous with the preventive stage—for in this we endeavour to thoroughly understand the *healthy* body with a view to combating those tendencies which threaten to bring it into the pathological condition in which it first comes under the purview of the medical practitioner. There is no need to emphasise the fact that to prevent a disease is more important than to cure it, for no matter how skilfully we set to work in the pathological stage, there is left some injury to health, some scar which we were better without.

Now, at the present time the whole interest of teacher and student is engrossed in the treatment and cure of existing disease because the importance and practicability of applying preventive measures to all diseases is not realised by the laity and only partly realised by the

medical profession who are not encouraged to push the principles of prevention since, in the present state of public opinion, they do not pay. A medical man would starve if he had to depend for a living on giving advice to his patients how to prevent disease, and the farthest he gets in that direction is to throw in a few words of advice with his prescription or bottle of medicine as to how to prevent a recurrence of the complaint for which the patient consulted him.

My next point is how to remedy this state of affairs and to get medicine on to the physiological stage. The first thing to do is to educate the laity, and this can only be done by starting to teach the child hygiene as soon as it is born and following this up by appropriate instruction through its school career, right on to adult life, and this practically means systematic instruction in physiology. Having mentioned this, I will leave the matter here, as we are at present concerned with the training of the medical man, for hygienic reforms, after all, have always started with the medical profession and by degrees filtered down to the general population. The best example of such a process are the altered views on alcohol in health and disease which prevail now as compared with those of the early and mid Victorian era.

Having arrived at this conclusion, I now ask how is the attitude of the medical practitioner towards disease to be so altered that he will come to look at it from the physiological or preventive standpoint rather than the pathological? To this my answer is that following up his instruction in hygiene at school you must so alter and adapt his *whole* medical training that he will come to look on medicine as means of preventing rather than curing disease. This does not mean that we must neglect the study of pathology, but rather that it should be taught as a branch of physiology. The two subjects are complementary to one another, and interdependent, and should not be presented in watertight compartments as if they were some thing totally different. For instance, in speaking of the physiology of the kidneys and the lungs, the teacher should give an outline of the pathology and histology of these organs, and likewise the pathologist, when treating of the diseases of these organs, should give a résumé of their physiology. It is not, however, advisable or necessary to wait till the student is in his second year before beginning hygiene, for even the preliminary sciences of biology, chemistry and physics lend themselves to the inculcation of many hygienic and preventive lessons, such as those connected with the influence of environment in biology, the hygienic properties of water, foods, etc., in chemistry, and the health-giving properties of the physical condition of the atmosphere, and the effect of heat and cold in the teaching of experimental physics.

In the teaching of physiology and pathology, the teacher, who is generally a fully-qualified man, will have little difficulty in pointing his hygienic and preventive lesson at the end of each demonstration or lecture. The same thing applies to the lecturer on clinical medicine and surgery, though the latter does not lend itself so well to the teaching of hygiene since its province is pathological and curative. Every lecture and chemical demonstration should wind up with a short dissertation on the causes and prevention of the diseases in question and the importance of prevention emphasised. As an illustration, I might take kidney disease and arterio-sclerosis. These diseases, either separately or combined, are responsible for a great deal of illness and incapacity or death about middle life when a man should be most useful and ought to have sufficient physical powers left to make the greatest use of his experience. Both these diseases are preventable, but can scarcely be called curable except in a very

restricted sense. In these diseases the teaching of prevention involves a consideration of diet, work, alcohol, various infections and heredity, subjects which are but lightly, if at all, touched on in the ordinary text-books of medicine, but could be kept in view if the authors of lectures and books were thoroughly imbued with the importance of prevention.

Newman laid great stress on a study of the early beginnings of disease, but I would go farther and lay stress on the pre-disease stage, so that when a patient comes to the doctor with the information that his family are liable to certain diseases he may be in a position to indicate how his client is to avoid the rocks on which his ancestors suffered shipwreck.

So far, I have said nothing about Public Health or State Medicine, but if the first part of the programme is carried out, as I have outlined above, it follows that when the student arrives at his fourth or fifth year and has to attend lectures on Public Health, he will come with a mind prepared to profit by the lectures and demonstrations, and will find that State medicine is only the application by the State or Municipality of principles with which he is already familiar to the general population. He will there learn what his position is in the commonwealth, his duties and obligations towards his fellow citizens, and will cease to look upon himself as a mere dispenser of medicine and adviser to those already broken down. As regards the teaching of Public Health and State medicine, I think in addition to the lectures there should be a certain number of practical demonstrations of insanitary and sanitary conditions on the district, so that after one has given a lecture on ventilation, for instance, the students may be given a practical demonstration of how houses should and should not be ventilated.

There are certain practical difficulties in giving these demonstrations, but with a desire to teach and learn on the part of the lecturer and student respectively I think they can be overcome.

Lastly, if you want to interest your students more directly in the subjects of preventive medicine and hygiene, you cannot do this better than by insisting that examiners turn their attention to those subjects and so frame their questions that the student must make himself acquainted with these aspects of medicine. If, however, teachers will only use their opportunities to inculcate the principles of prevention of disease with its cure, it follows that as examiners are recruited from among the teachers, the subject of hygiene will, in the long run, not be neglected at the examination.

Honours.

O.B.E.

Hon. Major H. J. Corin, L.D.S., R.C.S.

Mentioned in Despatches.

The names of the following officers are mentioned for gallant services and devotion to duty, in despatches dated Nov. 8th, 1918, received from the Commander of the British Armies in France:—

A.M.S. (STAFF).

Lieut.-Col. (Temp. Col.) H. P. W. Barrow, C.M.G. D.S.O., R.A.M.C.
Lieut.-Col. (Act. Col.) H. Hewetson, D.S.O., R.A.M.C.
Temp. Capt. (Act. Major) G. W. Smith.
Capt. (Temp. Major) J. Walker, M.C.

R.A.M.C.

Capt. (Act. Major) J. A. Andrews, M.C.
Temp. Capt. (Act. Major) L. R. Broster.
Temp. Capt. H. H. Carter.
Temp. Capt. J. L. Stewart, D.S.O.
Capt. E. S. Taylor.
Capt. and Battn. Major A. Walker, D.S.O.
Temp. Hon. Capt. W. Wilson.

R.A.M.C.(S.R.)

Capt. (Act. Major) R. P. Ballard, M.C.
Capt. (Act. Major) A. L. Shearwood.

R.A.M.C.(T.F.)

Capt. (Act. Lieut.-Col.) L. D. B. Cogan.
Capt. (Act. Lieut.-Col.) J. Young.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR MR. EDITOR,—I thought perhaps it might be of interest to some of the readers of the GAZETTE, to read the impressions one has had of the recent wonderful events which have taken place at sea, and of which we of the Grand Fleet have been the wondering participants and spectators. The surrender of the Hun Fleet will for ever be classic and historic, and I thought that the story of it might not be out of place in the GAZETTE, that is as witnessed by a Guy's man, so that in years to come it will be known that Guy's was well represented in this, as in every big event of this war. There must have been a number of Guy's men present at that great "show." I have met Sam Wilson, and seen Parry Price. He was so much my senior I never knew him, but I had a long yarn with Sam after a great "revue," which was staged by his ship's company the other night. I met also R. F. Roberts, he is known to recent Guy's men, and I passed by Gie's ship, but unhappily I haven't seen him yet, not since his wedding day! It is a great joy to meet Guy's men up here at Scapa Flow, right up in the Orkneys, and I was so glad to meet Sam Wilson, we talked Guy's hard, he looks much the same as when I knew him just a little in my dresser days, and he was Lane's H.S. I was going over to dine with him but I couldn't get away. This is a dreadful place, so very desolate, but with a fair proportion of the Fleet in, it looks more cheery, especially at night with searchlights flashing around. I joined my ship up here when we were almost the only ship here, it was dreary enough then, somebody once described it as "frozen hell," because it is so impossible!

"Armistice Day" came to us as an inward joy, but we could not possibly give outward expression to our feelings; how glad I am you did at Guy's: the good old milk can, the emblem of the pre-war spirit of Guy's which one loves so much—it was good to read about it all in the GAZETTE, and I am longing to see Thomas's statue again! We had an Armistice Concert on board; the men had "spliced the main brace," that means an extra round of rum, and were cheery enough, and they gave vent to their feelings by singing song after song, some of them the most sentimental and sloppy songs too, but the average "matelot" loves them, and so we sat in the front rows and sang too! The armistice begun, we went on as usual up here by ourselves doing gunnery trials. It was difficult to raise enthusiasm over it, but I suppose it is for the next war!

One day we suddenly got orders to proceed to Rosyth, and we knew then we were not going to miss the great events of the 21st November; how glad we were! Through the mist, as we steamed up the Firth of Forth we could see the leviathans of naval warfare who were shortly going to witness the results of their silent victory, but none the less great because their guns did not speak. We arrived at our billet well below the Forth Bridge, and as the mist lifted we saw ships of all classes busily engaged in cleaning and painting, for on the morrow our King was going to inspect his Navy before they sailed to engage the Hun Fleet, not in awful battle as they had longed, but in wonderful silence to lead them into captivity. The inspection of the King was interesting and fascinating; all ship's companies lined up to the order "cheer ship," and as the destroyer steamed up and down the lines of battleships, battle cruisers, light cruisers, warships of every class, there followed wave after wave of cheers, one long continuous crescendo, then a dying away, followed by a tornado of cheering perhaps from almost a thousand throats from a big battle cruiser. It was a holiday all that afternoon, a sailor's "make and mend." I went ashore and played Rugger against another ship in our squadron; we were all thoroughly excited at the prospect of meeting the Huns the next day, the memorable Thursday, November 21st—up till then it was impossible to realise what the surrender meant, we could not believe it.

We got under way early that morning about 5 a.m.; the gates of our wonderful boom defences were open and silently, almost stealthily, the vast Armada of ships slipped out into the open sea while it was still dark. The whole of the Grand Fleet was there, and American ships and representatives of the French Navy. I was up early, and I shall never forget the sight the morning light revealed: it was a gorgeous sunrise there, out in the North Sea, and silhouetted it seemed wherever one looked were the shapes of British ships, and near by in perfect line the ships of our squadron, the line after line as far as one could see. My experience of the Navy is so small, but I doubt if even the most veteran sailor ever saw such an impressive sight as it was to see all our Fleet out, and on such a mission!

We were early at the appointed meeting place, defined merely by latitutde and longitude and impatiently, it seemed, the ships cruised round, circling, turning, like an impatient horse waiting for the homeward dash. Soon a message came flashing by wireless from the Huns, penitent at being late, but their condensers or something were not working well; it was too pathetic, in a way, this much vaunted, much boasted Fleet saying "they were sorry they were late"! We still waited, steaming slowly round and round, and I got some excellent shapshots of our latest light cruisers, looking pretty almost with the sun shining on them. Overhead airships and aeroplanes were humming away; they were having a good time scouting for their prey. Soon we heard our outriders, as it were, had met the Huns, and every glass in the ship was concentrated on the direction whence the Huns were expected. Slowly they came into sight, big, dark hulls, some magnificent ships, too. We

spotted them by the silhouette with which our Secret Service has supplied every ship. The Huns steamed slowly up between the two lines of our ships, lines separated by about five miles, and the Huns, headed by a British light cruiser, steamed up the middle. It was a magnificent sight, and to a British mind an inexplicable one, a despicable one, too. We could not realize that this was really the Hun Fleet for which the British Navy has silently and bravely watched and waited to deal a death blow in an awful Armageddon of the sea. This cringing Fleet, arriving with its tail between its legs, surely this could not be the German High Seas Fleet, for years the arrogant pet of an arrogant Master, but as we picked out the familiar names, Derfflinger, Von der Tann, Moltke, and the like, we knew indeed that this was the enemy which had boasted and toasted "der Tag," but this was our "Day," and a very different one to theirs, that only of their dreams! I spoke to a fine specimen of English sailor as we stood and watched, a petty officer, and he said to me, "I can't believe it, sir. I was glad when we went to action stations this morning, for I would never have trusted 'em; and we did want a go at 'em, too!" It was, indeed, hard to believe, and only since have I fully taken it in, and that was when I saw them again. My ship was at the end of the line which went out, but when the Huns had got near the middle of the lines opposite Admiral Beatty's flagship, the *Queen Elizabeth,* we led the way home. We rushed back at about 25 knots, and we could not help feeling a triumphant note in the very vibration of our engines, it was a victorious return, and we felt conscious as we sat down to a very late lunch in the wardroom, that "we had seen strange things to-day."

Later in the day throughout the Fleet there was a thanksgiving service for the victory; it was most impressive. The captain took our service, saying, "We are going to give thanks to God for the great events of to-day." Meanwhile across the waters came the toll of many bells calling men to church, and one knew that the whole Fleet was assembling to thank God. We sang "O God our help in ages past"; how they sang those men, all of them, from Admiral to the smallest marine drummer-boy there must surely have been a feeling of thanksgiving for the wonderful bloodless victory, none the less wonderful because it was bloodless. There were prayers, and then "God save the King," and the gathering broke up, to think about it still.

My ship soon left Rosyth and returned here, escorting the first of the German ships to their internment here at Scapa, and every day following batches of ships have arrived escorted by various squadrons of our Fleet. When and only when I saw the ships close, here at Scapa surrounded by our Fleet, their guns all covered, absolutely empty of shells, could I realise that victory is ours, that the Hun Fleet no longer exists as a force, it is a useless non-entity floating on the waters.

To-morrow we bury a Hun sailor; could anything tell more of victory than a Hun sailor dying of influenza here in the Holy of Holies of our harbours; for a Hun has never been here before; this one came in captivity and died in captivity; poor beggar, little did he think he would end his days in Scapa Flow! We of the Navy are wondering now what next; there is very little more work to do, in which doctors are likely to be needed other than the peace complement. and we want to get back to enjoy the fruits of Peace to realize what it means; and as a doctor I want to know what of the future. Horrid rumours of State medicine still blow up here, but I would rather face the snares of State medicine on the beach than the snares of idleness on the sea. Give me leave, a look at dear old Guy's, and then give me work, and I shall go on being a happy man! I hope I have not been too boring, and forgive me, Mr. Editor, if I intrude too much on your space. My chin chin to all at Guy's I know well.—Yours sincerely,

HAROLD O. LONG.

H.M.S. *Cleopatra,*
November 30th, 1918.

SIR,—Mr. Steward's admirable exposition of the value of B.I.P., in your last issue, exemplifies how history repeats itself, albeit in a more refined way. In the late "seventies" I well remember how we dreaded a compound fracture, for it almost always meant death or loss of limb. It was then that Mr. Jacobson was the first surgeon at Guy's to pack the open wound with about as much iodoform as it could contain. From that moment a compound fracture was hardly more feared than a simple one. The literature of the time shows the objections that were raised to the use of this drug, partly on account of occasional iodoform poisoning and partly because in the laboratory iodoform failed to destroy organisms; and it was even asserted that some throve upon it. The chemical interaction between the drug and the tissues was overlooked, the conditions in the wards and in the laboratory being very dissimilar. Mr. Steward's insistance on the sparing use of B.I.P.—which after all is but diluted iodoform—is the refinement that late experience has introduced. and if borne in mind and acted upon, all objections to the employment of the drug disappear.—Faithfully yours,

C. H. GOLDING-BIRD.

DEAR MR. EDITOR,—Here is a history of, I hope, a unique misfortune that deserves to be recorded. I separated the adhesion of a soft palate to the naso-pharynx caused by a past syphilitic ulceration in a healthy man æt. 33 years.—with difficulty. As he was fidgetty immediately after operation and was endeavouring to withdraw the necessary plugs, the anæs-

thetist injected hypodermically less than half a grain of morphia. In an hour and a half he almost died in my absence. Under various stimuli and liberal belladonna injections he partially recovered, then relapsed into typical opium coma, pin-point pupils and slow respiration. Finally he succumbed, breathing four times in the minute, five hours after the injection. The Forensic authorities declare that one grain morphia is the least that has proved fatal. Have any of your readers ever met with so untoward an experience?—Yours sincerely,

VAUGHAN PENDRED.

326, Upper Richmond Road,
East Sheen, S.W.
Dec. 29th, 1918.

DEAR MR. EDITOR,—I congratulate you on your admirable War Memorial Number. I should like to make two suggestions.

1. Send round a typed copy of the list of those who have died to the Staff of the School and Hospital for further details to be added, and if necessary write to relatives for details. In many cases no note is given as to date or place or manner of death, and in others no note of hospital appointments, sports activity, etc. I should like to see greater uniformity of treatment in this way.

2. In the March revised issue publish pages 410 to 464 separately, with a suitable introduction written by somebody like Dr. Hale White. Let this be issued also in a special binding, as innumerable Guy's men would like to keep it.—Yours sincerely,

ARTHUR F. HURST
(Lieut.-Col. R.A.M.C.)

Seale Hayne Military Hospital,
Newton Abbot.
Jan. 9th, 1919.

Papers by Guy's Men.

Herbert French, M.D. Oxon., F.R.C.P. Lond., Lieut.-Col. R.A.M.C. (in collaboration with Adolphe Abrahams, M.D. Cantab, M.R.C.P., Major R.A.M.C., and Norman Hallows, M.D. Oxon., D.P.H., Capt. R.A.M.C.): A further investigation into influenzo-pneumococcal and influenzo-streptococcal septicæmia.—*Lancet*, Jan. 4th, 1919.

G. F. Still, M.D., F.R.C.P. (in collaboration with A. Harden, F.R.S., and Silvester S. Zilva, Ph.D., M.Sc.): Influenza scurvy—the antiscorbutic factor of lemon juice in treatment.—*Ibid*, Jan. 4th, 1919.

W. R. Reynal, M.A., M.D. Oxon., M.R.C.P., Capt. R.A.M.C.: Hysterical vomiting in soldiers.—*Ibid*, Jan. 4th, 1919.

W. Hale White, M.D. Lond. and Dub., Col. R.A.M.C.(T.): On the teaching of medicine.—*Ibid.*

J. A. Glover, M.D. Camb., D.P.H., Capt. R.A.M.C.: Six cases of purulent broncho-pneumonia associated with the meningococcus.—*Lancet*, Dec. 28th, 1918.

Philip Turner, M.S. Lond., F.R.C.S. Eng., Major R.A.M.C.: The triangle splint in the treatment of compound fractures of the humerus.—*The B.M.J.*, Dec. 28th, 1918.

Ward Concerts.

CLINICAL.

The usual Christmas concert was held on Dec. 28th, 1918. The wards had been tastefully decorated after endless trouble and time spent, most of the panels, friezes, lamp shades, and other decorations having been painted by Nurses Gait and Siddons. People were no doubt attracted by the poster announcing the concert, as a goodly company had assembled when the concert was started punctually by a pianoforte solo.

Much talent was displayed and magnificent singing was heard on the part of Miss Murray, Miss Baines and Miss Remington. Humourous songs were supplied by Mr. and Miss Gaywood, and some violin solos were much appreciated.

Local talent was well in the foreground, Nurse Gait singing magnificently and obtaining a deserved encore. Mr. Millar came in for his usual rousing reception. Messrs. Carlling and Thomas sang their "nigger songs," and both received an encore. Mr. Braithwaite and Mr. Burville-Holmes also sang, the latter also singing a duet with Miss Gait.

As a diversion from singing, Mr. Marais played some 'cello solos, Mr. S. Cohen a violin solo, and Major Brown gave a conjuring display. Two children from Miriam, after the interval, during which an excellent tea had baen provided by Sister Clinical, gave a small sketch, which they had been taught by Nurse Rose. Mr. Siggs deserves especial thanks for accompanying songs, etc., in his accustomed style the whole afternoon.

For making the concert such a huge success, to Sister Clinical, the nursing staff of Clinical, Mr. Remington, who stage-managed the proceedings, the artists both from outside and local, and to numerous others who so kindly helped, all thanks are due.

ESTHER.

A delightfully informal concert was held in this ward on Monday, Dec 30th. An excellent programme was arranged, and many local favourites, such as Messrs. Bonar, Lansdowne, Sawday and Carling, regaled visitors, patients and nurses alike with popular melodies.

The celebrated little Miss Kathleen Buschell gave some amusing monologues, both before and after the interval. Mr. Dench rendered some Irish songs with great ability, and Miss Sherring played the violin excellently. Songs were contributed in a most enjoyable manner by Miss Remington and Miss Layton. Mrs. Frost accompanied ably throughout the performance.

Combined with these, and the untiring efforts of Sister Esther and nurses, the concert was a huge success. After three cheers were given for Sister, three for the artists and artistes, by the M.C., Mr. Remington, cheers were called for the latter.

EYE.

In spite of there being four entertainments in the Hospital on the same afternoon, there was an excellent attendance at a most enjoyable concert in the Eye Wards on Friday, Dec. 27th. All the items were greatly appreciated. Miss Renée Maxwell, the Australian singer, began the concert. The high standard she set was well maintained by little Misses Audrey Hughes and Peggy Willoughby, who sang and recited in a most fascinating manner, and by the Misses Ludlow and Betty Cullen. Mr. Sawday supplied the local talent and Mr. Siggs (without whom no Hospital concert could get on) accompanied in his usual brilliant style.

During the interval a sumptuous tea was provided by Sister and the nurses. The proceedings closed with hearty cheers for the performers and Sister Eyes.

LYDIA AND JOB.

The great function which these two wards produced was the Christmas Tree, preceded by Punch and Judy Show. It took place in Lydia on Friday, December 27th, and all the visitors who came had a highly amusing afternoon with the children. The Punch and Judy Show, kindly provided by Mrs. F. J. Steward, was greatly appreciated. It was far funnier to watch the excited faces of the 120 or so children who had gathered from all wards of the hospital, than the actual antics of Mr. Punch. An excellent tea was provided for all visitors in Job Ward, while the children feasted in Lydia. After this to the amazement of the children, Santa Claus (W. H. Cellier) appeared through the window, and the distribution of gifts began. All seemed charmed with their presents, and very soon little girls were nursing dolls and boys playing trumpets until a very enjoyable afternoon terminated with three cheers for Sister and Santa Claus. The only unfortunate thing was that Sister Lydia was at the last moment prevented by illness from being present. Few visitors failed to remark on the tasteful way in which the ward was decorated.

CHARITY AND LUKE.

The Concert in Charity, at which Sir Alfred and Lady Fripp presided, took place on Xmas Eve, and was a great success. Much credit is due to Sister for her charming decorations, and a dainty tea was served in Luke which was much appreciated. Sir Alfred was fortunate in providing so many stage favourites. Mr. Coyne and Miss Thacker sang a pleasing duet about Yuletide. Mr. Fred Dupree told funny stories with his usual vivacity. Willie Lewis and party in their Welsh costumes received encores from Welsh members of the audience. Helen Mar's piquant jokes caused ribald merriment among the more sporting patients.

Mr. Corelli Windeatt's well-balanced orchestra gave pleasing selections from popular plays of to-day. Unfortunately Miss Winifred Barnes was prevented by illness from participating. Other artistes also from Wyndham's, Apollo, Drury Lane and Gaiety, added to the merriment.

The thanks of all for this thoroughly enjoyable concert are due to Sir Alfred for his kindness in securing so many "stars," and to Sister for her generous hospitality.

Headquarters, London District,
Horse Guards Annexe,
12, Carlton House Terrace,
London, S.W. 1.
17th December, 1918.

To the Chairman, Guy's Hospital,

Dear Sir,

It has been intimated that you are desirous of closing the Officers' Section, Guy's Hospital, on 31st December, 1918.

The Officer i/c Queen Alexandra's Military Hospital has been instructed to evacuate the patients before that time (*i.e.*, 30/12/18).

On behalf of Major-General G. P. T. Feilding, C.B., C.M.G., D.S.O., General Officer Commanding, London District, I wish to offer my sincere thanks and appreciation for the excellent work that has been carried out there during the past four years, and I should be greatly obliged if you would be so good as to convey to the Medical and Surgical Staff, and the Nursing and Subordinate Staff our sincere thanks and admiration for their devoted and excellent work in connection with the treatment comfort and general welfare of the sick and wounded patients that have been accommodated during this long period.

Yours very faithfully,
(Signed) S. MACDONALD,
Major-General,
D.D.M.S., London District.

A Case of Friedlander's Bacillus Septicaemia of Sudden Onset and Rapidly Fatal Termination.

Henry G., æt. 74, was admitted into Addison Ward under Dr. Poulton on 19th September, 1918, in a collapsed condition with incontinence of urine and fæces. Apart from slight morning headache during the preceding week he had been perfectly well until the day of admission. There was a history of slight heart and kidney trouble the exact nature of which was not ascertained. An operation for removal of the prostate had been performed a year before, the result of which was said to be completely successful.

On the morning of the 19th September, 1918, he complained of slight chill and sore throat; he vomited on the way to the station.

At his office at about mid-day he was seized with a sudden attack of faintness and giddiness. He was brought up to the Front Surgery at 3.30 p.m. completely collapsed, but conscious and mentally quite normal. He had incontinence of urine and fæces. In this condition he was taken in to Addison Ward.

On admission the temperature was 99°F., the pulse about 100, and respiration 26 per minute. The physical signs were—respiratory system quite normal; heart enlarged both to right and left about half an inch beyond normal limits on either side. A definite systolic bruit in the mitral area, with clear pulmonary and aortic second sounds. There was some slight redness of the throat, but no enlargement of the tonsils. There was no albumen, sugar, or blood in the urine.

By 6 p.m. the temperature had risen to 102°, respiration became more rapid, 33, pulse quicker and feebler. At 11 p.m. he had a rigor, and the temperature rose rapidly to 105·4°. He became unconscious, with very shallow and rapid respiration. The pulse was extremely fast and at times imperceptible. The blood pressure taken at this time was 90 m.Hg. There was an extensor reflex in the right foot. A tentative diagnosis of cerebral hæmorrhage was made. The patient died at 12 midnight, the whole illness having lasted little more than 12 hours from the onset of symptoms.

At the autopsy the most marked feature was an intense hæmoglobin staining of the endocardium, the aorta, and vessels generally. Fairly extensive atheroma was found involving principally the descending aorta, coronary arteries and cerebral vessels. The heart was dilated and flabby, lungs engorged, kidneys slightly granular, liver pale and fatty. The brain was of large size, but careful examination revealed no macroscopic abnormalities. At the autopsy a tentative diagnosis was made of septicæmia probably of naso-pharyngeal origin. Subsequent cultivation of the spleen gave a pure growth of Friedlander's bacillus. The heart was examined microscopically and showed coronnary atheroma and an advanced degree of diffuse fibrosis. There was sufficient disease of the heart muscle to explain why such a patient should succumb rapidly to an acute infection.

I am indebted to Dr. Poulton for permission to publish this case.

G. B. D.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

To the Editor,

Guy's Hospital Gazette,

Dear Editor,

Attribute I pray you in no wise the irregularity of my correspondence to my fault for indeed it has been my misfortune. Influenza has made havoc among my kinsfolk in Hong Kong and reduced my family to a mere skeleton. Even the emperors temperature (measured by the mouth) has been three days subnormal which the books say means a sorry rice crop next season. But I am ashamed to worry you with our domestic misfortunes. I have just heard a story from a Japanese naval officer which in spite of the notorious mendacity of that nation I am disposed to credit inasmuch as it refers to one of your surgeon sublieutenants. I will try to recall the story as it was told me.

The Japanese officer was taking passage by an Italian cargo boat carrying currants and other dried fruits from the Gulf of Corinth to Lemnos. The Italian crew at the last moment refused to go to sea unless the ship were bound for an Italian port, so the barque was forced to put in at Taranto. There was an important English naval officer on board, a fleet surgeon, who resented greatly being diverted to this port, which he considered insanitary. The great surgeon I understand had been very angry at being made to take passage by a preserved fruit cargo boat and had sent a signal of protest. It is said he had quarrelled with a certain Commander D and had written to the admiralty that all attempts to get reason from him were fruitless. This was the Commanders revenge. The surgeons journey at least was fruitful. Throughout the journey the great surgeons mien was described by the Japanese officer as suggestive of the second stage of a eastern execution.

Shortly after entering the harbour, a signal came from a neighbouring destroyer and was handed to the surgeon. It ran—

P.M.O. to P.M.O.

Request the loan of a saw and a pint of chloroform.

Surg. Sub-Lieut. X.,
Medical Officer,
H.M.S. *Lymphatic.*

At this signal the great mans rage was unbounded.

P.M.O. to P.M.O. indeed; P.M.O be damned. M.O. be damned. He is no M.O. Not the hundredth part of an M.O. or the thousandth part of a P.M.O. A dogs body, a probationer surgeon's dog's body, a sub-lieutenant probationer surgeons nobody's damned dog's body.

To make matters at this moment the sender of the signal entered the ward room. I am trying to describe the scene as the Japanese officer repeated it to me.

"Are you the originator of this absurd signal," said the surgeon. "Are you the medical officer of the *Lymphatic*?"

"Yes, sir."

"No, sir. You are nothing. You are not a medical officer. You are a probationers dogs body."

"Thank you' sir. May I request——"

"No you may not. A junior officer submits, he does not request."

"May I submit ——"

"Not to-day. I am busy. Submit in writing next week."

"I am going on leave, sir."

"You are not going. Why are you going? What urgent reason have you?"

"I have an invention, sir, I want to submit to the lords commissioners of the admiralty."

"What is your invention?"

"I would rather not say, sir. It is a cure for syphilis."

"I insist upon knowing. What is your recipe?"

"Well, sir, if you insist, I may say it varies with the idiosyncrasy of the individual."

"How do you mean?"

"Well, sir, for a person like you it would be a mixture of brass filings and soda water."

Your humble Servant,
HO HO.

Appointments.

Medical School Appointments

JANUARY-MARCH, 1919.

Dressers or Clerks in Special Departments:—

A. *Throats* (Mr. Mollison). *Orthopædics.*—Messrs. W. R. Carling, S. Cohen, C. H. St. John and N. V. Wadsworth.

B. *Throats—Genito-Urinary.*—Messrs. W. J. McB. Allan and W. A. Turner.

C. *Children, Eyes* (Mr. Eason).—Messrs J. V. C. Braithwaite, I. R. Florence, M. A. R. Khalifa, W. W. Payne and G. K. Reeves.

D. *Skins, Nerves, Eyes* (Mr. Ormond).—Messrs. W. G. Hay, R. C. B. Ledlie and A. E. Sawday,

Obstetric Dressers.—Messrs. W. F. Attwater, K. M. K. Duff, G. H. Howe, H. Le Vieux (Mr. Bellingham Smith); W. Mark Brown, G. P. Lindsay, C. M. Probert, W. H. Russel Thomas (Mr. Chapple).

Surgeons' Dressers.—Messrs F. W. Crook, W. Remington (Sir Arbuthnot Lane); E. J. Crisp, H. A. Crowther, G. Massie (Sir Alfred Fripp); I. Rosenberg, M. Sidkey (Mr. Steward); D. J. O'Meara, H. A. A. Pargeter, B. M. Tonkin (Mr. Fagge).

Assistant Surgeons' Dressers.—Messrs. J. Sullaiman, S. Wilson (Mr. Rowlands); M, Maizels. E. H. Richards (Mr. Turner); J. H. Burn, P. Couacaud (Mr. Hughes); K. J. H. Davies, H. J. Lyon (Mr, Bromley).

Medical Ward and Post-mortem Clerks.—Messrs. J. N. Alexander, C. I. C. Gill, A. Mikhail (Dr. Hale White); I. B. McCann, A. McKenzie, R. M. Patterson (Dr. Shaw); W. D. Doherty, T. W. Turner, R. E, Williams (Dr. Fawcett), J. Arnovitch, G, H. Oriel, J. J. F. Rooney (Dr. Beddard).

Student Assistant in the Bacteriological Department.—Mr. E. F. Wilson.

Student Demonstrator of Microscopical Pathology.—Mr. S. Rose.

Pathological Assistants to the Demonstrators of Morbid Anatomy.—Messrs. St. G. B. D. Gray and W. W. Payne.

R.A.M.C.

Temp. Capts. to be Acting Majors.—A. A. Miller, W. F. Box.

To be Temp. Capt.—E. Ashby.

Temp. Lieut. to he Temp. Capt.—W. F. Lawrence.

Officers relinquishing their Commissions.—Temp. Capts. F. M. Longson (on account of ill-health and to retain the rank of Capt.). W. H. T. Jones, F. G. Goble, A. M. Roome, H. W. Barber, H. S. Turner.

Territorial Force.

Capt. (Acting Major) G. T. Willan, D.S.O., is granted the pay and allowances of his acting rank.

3rd Southern General Hospital—Capt. J. F. Robinson is restored to the establishment.

Special Reserve of Officers.

Lieuts. to be Capts. N. H. S. Maelzer.

Capt. H. M. S. Turner is seconded for service.

Rugby Football.

GUY'S "A" v. NEW ZEALANDERS' F.C.

Guy's "A" team showed remarkable keenness, and an example to the rest of the Hospital, in rising early in the morning so as to play at Stevenage, and then return to Honour Oak Park in time to assist in the defence of the milk can. The match was rather a mistake in that the New Zealanders were far too good for any second team. Guy's, however, played exceedingly well and put up a stiff resistance. Shaw and Crisp both distinguished themselves on the defensive, the latter tackling time and again, breaking up a N.Z. run through.

The forwards all played well, and several times rushed the ball down the field. Jones broke through after a rush, but unfortunately mistook the marking of the field (there were two lines marked out) and failed to score. The team was really beaten by the fine work done by the N.Z. three-quarter line. Final score: N.Z., 80; Guy's "A," 0. Team:—

GUY'S.—S. Rose (back); H. B. Jones (Capt.), T. A. Shaw, J. E. Crisp, Greenway (three-quarters); S. P. Meacock, Playwright (halves); J. A Currie, L. Lavine, R. Brooke, W. C. Collwill, Jeaves, H. L. Berstein, Seward, J. Goodenough (forwards).

GUY'S v. LONDON CANADIANS.

Played at Honour Oak Park on Jan. 4th. The Canadian team was considerably strengthened by the inclusion of several men from St. Thomas's, and consequently they were able to put up a much better fight

than they had done earlier in the season. The Hospital were not quite at full strength, Cellier, Day-Lewis, and Aspinwall being unable to turn out.

The ground was in a hopeless condition, and as a result play was chiefly confined to the forwards. The Hospital pack, finely led by Doherty, were in all respects superior to their opponents. The Canadians rarely got the ball out of the scrum.

Following the kick-off, Guy's at once carried the game into the Canadians' "25," and pressing strongly, a score seemed probable, but the Canadians relieved matters by intercepting a pass and gaining considerable ground before they were stopped. A series of short ushes followed, in which Bekker was always to the fore, and for the remainder of this half play was mainly in the visitors' "25." On several occasions the Hospital came very near scoring, but they were unable to break through the defence.

On changing ends, the Canadians attacked vigorously, and more than once the Guy's line seemed to be in danger, but time after time the Hospital forwards, in fine rushes, in which their footwork was particularly good, carried the ball to the other end of the field. On one of these occasions the Canadian full-back had his kick charged down, and Watson dashed over the line to score; Crook failed with the kick.

Guy's continued to have the best of matters until the Canadians' right wing intercepted a pass, and kicking the ball hard over the line followed up and scored. The goal kick failed.

On resuming, Guy's once more forced matters into their opponents' territory. Following some hard scrum. maging in front of their goal, the Canadians were penalised and Reitz kicked a good goal.

From now onwards the Hospital had all the best of it, and just before time the Canadians were again penalised. Reitz kicked the ball into his own hands, and running strongly passed to Krige, who scored in the corner; the try was not allowed, however, and the end came with Guy's winners by a penalty goal and a try (6) to a try (3).

On returning to the pavilion, further discussion concerning the last try ensued, and as a result the referee decided to allow it. No goal kick had been taken, however, so the score was left at 9—3.

The condition of the ball made much passing an impossibility, and so the outsides had few chances of showing what they could do. The forwards played one of their best games for the season, and Bekker was as indefatigable as usual behind the scrum. Team :—

GUY'S.—F. Reitz (back); K. M, Duff, E. J. Crisp, P. Krige and L. Marais (three-quarters); F. Bekker and H. J. Playwright (halves); W. D. Doherty, A. H. Shelswell, F. W. Crook, L. K. Watson, B. L. Laver, P. Morrison, J. van der Merwe and D. J. O'Meara (forwards).

Association Football.

A general meeting of the Association Football Club was held in the Physiological Theatre on Thursday, Dec. 19th, Dr. Fawcett in the chair. After the Chairman had emphasised the desirability of recommencing "soccer" as soon as possible, the meeting proceeded to the election of officers, which resulted as follows:— Hon. Secretary, G. P. Lindsay; Hon. Treasurer, W. R. Carling; Committee, E. G. Greenwood, H. G. R. Canning, E. C. Gill, E. F. Wilson.

It was proposed and carried that there should be one member of the Committee from the Dental side, and the meeting agreed to leave it to the Committee to co-opt this member in due course.

The meeting closed with a vote of thanks to Dr. Fawcett for presiding.

Births.

LEE.—On Nov. 5th, the wife (née Allday) of Captain Harry Lee, R.A.M.C.(T.), of 6, Park Square, Leeds, a son (Arthur Guy).

BROMLEY.—On Dec. 4th, at the Warden's House, Guy's Hospiial, the wife of Capt. Lancelot Bromley, R,A.M.C., a son (John Lee).

Marriages.

DODD—BUTLER.—On 31st Dec., 1918, at Eccleston Church, Chester, by the Rev. Clement E. M. Wilson, Capt. Herbert Grantham Dodd, R.A.M.C. (T.F.), elder son of Dr. and Mrs. Arthur H. Dodd, of Hove, to Emma Ethel, youngest daughter of the late Mr. and Mrs. James Butler, of Bedford.

LONG—HOOK.- On 1st Jan., at Southwark Cathedral, by the Rev. E. N. Sharpe, M.A., Harold Octavius Long, Surg.-Lieut. R.N., H.M.S. *Cleopatra*, son of Mr. and Mrs. Long, of Forest Hill, to Ada Violet, daughter of Capt. and the late Mrs. Edward Hook, of Cardiff.

Deaths

NAISH.—On 18th Dec., after a long illness, Mary Alice Joyce, beloved wife of Godfrey Naish, L.D.S., of Beechcroft, Alton, Hants, in her 47th year. R.I.P.

WINTER.—On 3rd Dec., in British Honduras, of pneumonia, William Pollard Cecil Winter, M.R.C.S., L.R.C.P., in Colonial Medical Service.

G. P. L.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 797.] JANUARY 25, 1919. [SIXPENCE.

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Passim.

IT is our sad duty to record that the end of this month will bring the end of Sir Arbuthnot Lane's active work at Guy's. On the sheer magnitude of that work it would be presumption on our part to dilate. We know that the good wishes of many generations of Guy's men will go with Sir Arbuthnot, and we know, too, that the fortunes of Guy's will not cease to take a foremost place in his mind, as they have done in the past. The "last round," including operations, is to be on Friday, January 31st, when a welcome is extended to past members of Lane Firms who wish to take farewell of their old "chief."

ONE of the happiest features of the Christmas at Guy's which has just passed has been the re-appearance of old faces at the ward concerts and elsewhere in the hospital. Seldom does a day pass without the College dining-room having the opportunity to welcome back some old Guy's man. Presumably the majority of those who have left within the memory of this generation of students cannot be released yet. Older men with practices awaiting them obviously have the first claim. This is the principle embodied in the Central Committee's scheme of medical demobilisation, and we think it is only the commonsense of the question.

Meanwhile, however, the time for changing Resident Appointments has come round again, and still the number of newly-qualified men is insufficient to meet the vacancies. The following vacancies for Resident Appointments are announced for the 1st of February:—

2 House Physicians.
4 House Surgeons.
1 Ophthalmic House-Surgeon.
2 Obstetric Residents.
4 Out-Patient Officers.
4 Assistant House-Surgeons.
4 Assistant House-Physicians.
4 Assistant Casualty Officers.

Some of these appointments have recently been held by unqualified men. It is hoped that before long Guy's will regain its normal strength and have as applicants for its Resident Appointments a sufficiency of qualified men.

It is desired to assist, as far as possible, those men who, having served abroad, are anxious to return to Guy's to hold Resident and other posts.

One looks forward to the time when such men will become free to make application for appointments, and it is thought that even now applications might be made by men though not yet demobilised.

It does not seem likely that the entire appointment list will be filled by the present House Officers obtaining re-appointment and by those newly qualified, and therefore applications from those not yet demobilised would be welcomed, and should such men be appointed, that fact might bring about early demobilisation, as no doubt the Hospital would make a special appeal on behalf of newly appointed House Officers.

Applications should reach the Superintendent's Office not later than Wednesday, 29th January.

ANYONE who has worked in the Front Surgery knows the sort of depression existing which results from the shortage of senior men there. Evidence has not been lacking of late that the oversight exercised over the work of dressers has been insufficient. This has been most unfortunate, particularly from the dressers' point of view. But it is obviously inevitable with only one qualified Out-Patient Officer, as has been the case during the last three months. It is greatly to be hoped, therefore, that the vacancies for Out-Patient Officer will be filled, if only for the reason that, with more senior men in the Front Surgery, a dresser's work would become not merely the monotonous job of a sorting officer, but an experience of real worth with some permanent value to himself.

THE point has been raised of the perhaps unfortunate wording of the report of the Association Football Meeting published in our last issue. That one Dental man should be "co-opted to the committee" has been taken to infer that only as an after-thought did the meeting decide to include dental men. This, of course, would be beyond the power of such a meeting, and it is well known that dental men have the same privileges and responsibilities as other members of the Clubs' Union.

This may seem a small point, but in reality we believe it is indicative of a genuine difficulty. With regard to the Dental School, owing to the very special nature of their work and interests, it is obviously difficult for an Editor to keep in touch with all their doings, and for a secretary to get hold of the men he wants What seems to be necessary is some form of co-operation. When the Dental Society comes to be re-formed—and we understand that is being done as rapidly as possible—we suggest that one of its first acts be to appoint a Dental Correspondent, whose permanent function it would be to keep the GAZETTE supplied with Dental news. There is nothing revolutionary in this, and its achievement would be of considerable benefit both to the GAZETTE and also, we hope, to the Dental School. On another page it will be seen that, quite independently, this has been done.

THE last echo of Christmas festivities died away in the cheers led by the President of the Residents at the conclusion of the second dance in the Nurses' Home. The first was given by the Nurses, the second by the Residents, and both were a huge success. This was in no small part due to everyone's attempt to disguise their identity—some with complete success—by fancy dress costumes. The men, who were received by Matron in the Hall, for the most part appeared in their "Nigger" garbs. The Nurses are to be congratulated on their exquisite fancy dresses many of which were distinctly original, some comical, some highly decorative, all exceedingly beautiful. But here the pen gives place to the camera, for was there not a flashlight photograph? The gratitude which all felt for Matron's kindness was vociferously expressed by three very hearty cheers at the conclusion.

THE following extract from the *Indian Times* has been sent to us by an old Guy's man, one evidently not unacquainted with Theatre VIII.

CALCUTTA SURGEON'S SUCCESS.

CALCUTTA, December 5.

An unusual operation was performed at Medical College Hospital when Captain Green Armitage used plating in a case of a fractured leg. In this case Corporal Cole, aged about 30, sustained a fracture of his left tibia and fibula in conseqnence of a fall about a fortnight ago. The fragments were widely separated. Captain Armitage used a steel plate with bolts and nuts to unite the fractures in the same manner as broken wood is joined together by means of a plate. The Corporal stood the operation well and his present condition is reported to be favourable. Such operations are rare in Calcutta, although they have been carried out with successful results during the recent war.

Was it Hamlet who said, "The times are out of joint"?

WITH this issue we publish a photograph of the "Niggers," apologising for its tardy appearance.

THIS is the time when various courses of lectures are arranged by the Colleges of London University. We would draw attention to a course of six lectures on "Physiology and National Needs" held at King's College on Wednesdays at 5.30, commencing on February 5th. The second of the course, on February 12th, is a lecture by M. S. Pembrey, M.D., on "Physical Training of the Open-air Life." Prof. Starling, F.R.S., will be in the chair. Further particulars are posted on the notice board outside the Medical School Office.

THE CLUBS' UNION.

The increasing number of Students in the Hospital and especially the welcome return of old Guy's men, combine to make the renewal of the Clubs' Union a matter of the most urgent importance. Throughout the war many of the constituent institutions have, of necessity, completely lapsed. This state of affairs has not come about through lack of enterprise: the reasons for it are self-evident. For a greater part of the time the number of men has been barely sufficient to carry on the work of the Hospital, and that work has in no way decreased owing to the energies of other hospitals being diverted to military needs. There have been, however, one or two exceptions. The Rugby Football Club has, largely through the praisworthy efforts of a few, continued to maintain its existence. Others, such as the Physiological Society, have just struggled through. The time is now ripe to re-establish the Clubs' Union, and to this end the first step will be the formation of the Clubs' Union Council, consisting of six members of Hospital and School Staff and six representatives of the Students. The following are the constituent institutions:

The Athletic Club.	The Hockey Club.
The Cricket Club.	The Lawn Tennis Club.
The Debating Society.	The Pupils' Physical Society
The Dental Society.	The Reports.
The Football Clubs.	The Rifle Association.
The Gazette.	The Students' Club.
The Golfing Society.	The Swimming Club.

NON-AFFILIATED INSTITUTIONS.

The Christian Union.
The Physiological Society.
Guy's Hospital Musical Society.
The Pavy Gymnasium.

This may seem a formidable list, but it is one which all would do well to ponder. New men especially are encouraged to attach themselves to one or other of the Societies, which provide for their amusement and elevation. It will be for them not merely to join the society and fall in with a ready-made and smooth-running concern, but in most cases to build it up anew and revive its attractions, after the lapse. In the near future it will be necessary to have a general meeting, of which full notice will be given. Men are urged in advance to make a point of attending any such meeting in order that they may hear what is going to be done.

Clinical Lecture by Dr. Fawcett.

CASE 1.

Enlarged Spleen. Recurrent attacks of Hæmatemesis and Melæna. Jaundice. Positive Wassermann reaction.

GENTLEMEN,—The first patient I am going to show you is a man aged 25, who has a greatly enlarged spleen. Unfortunately the medical report containing the results of the examinations of his blood has been mislaid and I have to tell you from memory many of the important facts of the case. Fortunately, however, a most valuable abstract of his past history was sent to us by Dr. A. Evans, R.N., under whose care the patient was in the early part of 1917, and we are much indebted to him for the report.

Dr. Evans tells us that in 1912 the patient was admitted into St. Bartholomew's Hospital with a four months' history of jaundice and three months of passing pale "stools." The abdomen was said to have been enlarged for six weeks. The spleen was apparently the same size as in 1917; the liver was larger than in 1917, and two nodules were described as palpable on its lower margin. The only other points of interest from his record in St. Bartholomew's Hospital were that his gums were said to have bled easily all his life, and that a Wassermann reaction was positive.

The next stage of interest to us was in August, 1915, when he was admitted to the Royal Naval Hospital, Mount Stuart, for pain in the left side of his abdomen. He was jaundiced on admission and remained so for four weeks. There was a large mass in the abdomen in the region of the spleen. Dr. Evans states that from the notes available there appears to have been little difference at this time in the size of the spleen to that when in St. Bartholomew's Hospital. There was some degree of anæmia: red blood cells 4,000,000 and a low white cell count 3,500 c.mm. He was discharged to duty on 9th December, 1916.

On February 24th, 1917, the patient was again admitted to the Mount Stuart Hospital for a recent severe attack of hæmatemesis, he having been quite well since he was last in hospital. There was great pallor, melæna, an icteric dry skin, and spongy gums which bled easily. The spleen was much enlarged and the liver was just palpable. A "blood count" gave red cells 4,128,000 to the c.mm. and white cells 6,000, without any abnormal change in the differential white cell count.

He was kept under observation for three months and gradually recovered from the severe bleeding. His convalescence was interrupted by periods of pyrexia which were so marked as to suggest lymphadenoma, although no enlargement of glands was detected. During these febrile periods the gums became more spongy and bled easily, the spleen increased in size and became tender, and the man complained of acute pain in the left side of the back; his skin became icteric and dry and bile was found in the urine.

The patient was discharged from the navy, and in September, 1917, he had a second severe attack of hæmatemesis and melæna. He was admitted into John Ward in January, 1918, in connection with some investigations for the Pensions Board, and a few days later he had a third severe attack of hæmatemesis and melæna. On examination the spleen was found to be very large, reaching down, as you can feel, to the level of the anterior iliac spine, four and three quarter inches below the costal margin. There was a distinct tinge of jaundice in the conjunctiva and skin. The liver was not palpable, nor were there any irregularities to be felt over its surface in the epigastric area.

The Wassermann reaction was strongly positive. No signs of organic disease elsewhere.

The patient gradually recovered from this third attack of hæmatemesis and melæna, and although at first a "blood" examination showed there was considerable anæmia it was of no particular type. April 8th, 1918: red blood cells, 2,100,000; white cells, 3,120; Hb. 25 per cent; colour index 1·06. It was a "secondary anæmia" such as might be due to loss of a large quantity of blood, and his blood count recovered to one of 4,000,000 red cells by June, 1918. The white cell count varied, but, on the whole, was a low one, and on four occasions out of five was below 4,000 to the cubic millimetre. The differential "white cell count" was within normal limits. As you can see he looks now extremely well. He has been up for about four months.

After the attack of hæmorrhage in January, 1918, the spleen decreased considerably in size to about the level of the umbilicus, whereas, as you see it now, it comes down to one and a half to two inches below that level.

Now arises the question of diagnosis. We have here a chronic disease with great enlargement of the spleen and three attacks of hæmatemesis and melæna in twelve months. Naturally the first thing that came into our minds was "splenic anæmia," *i.e.*, a primary disease of the spleen of long duration associated with great enlargement of the organ and anæmia of "chlorotic" type with leucopenia; also a liability to hæmorrhage, especially from the stomach.

It was very important to determine whether it was a case of that kind, and if so whether the spleen should be removed. This symptom-complex has its origin apparently in the spleen, for removal of the viscus has in many cases "cured" the patient.

There are several points in the case militating against a diagnosis of splenic anæmia:—

(1) There was no permanent and typical anæmia, the blood count gradually returning almost to normal on recovery from the hæmorrhage. The colour index was not a low one, but there was a leucopenia. The blood condition in this patient does not of inself exclude "splenic anæmia," as apart from bleedings, attacks of anæmia may occur with recovery to the normal level in the intervals.

(2) Again, you may remember that Dr. Shaw has drawn attention to the fact that while in some of the cases of so-called "splenic anæmia" the anæmia becomes obvious before there is any great liability to hæmorrhage, yet, in another group, local hæmorrhages, especially from the stomach, precede the development of anæmia (*vide* G.H.R., vol. lvi.).

In the case of this patient, although there was anæmia, it was not a typical one. The striking feature of the case has been the severe recurrent gastric bleedings. However, the blood condition would conform to some of the cases included in the symptom-group of splenic anæmia, viz., the second class just referred to.

(3) The chief point to my mind contra-indicating a splenic anæmia was that in 1912, when admitted into St. Bartholomew's Hospital, the patient was stated to have had jaundice for four months and to have been passing pale "motions" for three months. Also that the liver was enlarged and two nodules could be felt in its lower margin.

When admitted to the Mount Stuart Hospital in 1915 he was again jaundiced and remained so for four weeks, and in 1917 on his second admission he was said to have exhibited an icteric dry skin.

In 1918, on admission under my care, the conjunctivæ and skin were of a pale yellow colour, and bile was present in the urine.

You may know that enlargement of the spleen occurs secondarily to, or in association with, some cases of cirrhosis of the liver, not

necessarily of alcoholic origin. In this case hepatic enlargement and jaundice were present at an early stage of the disease, viz., in 1912, and the liver was "lumpy."

In 1918 the liver could not be felt, nor were there any irregularities on its surface so far as we could detect. Thus, I came to the conclusion that it was much more likely the liver was the primary seat of disease, the splenomegaly being a secondary development. The suggestion put forward to explain the fact that the liver was not palpable in 1918 was that absorption of pathological deposits had occurred between 1912 and 1918 which accounted for the diminution in the size of the viscus.

(4) If the disease was originally situated in the liver, what was its nature? It was certainly not Laennec's alcoholic cirrhosis. Was it syphilitic? Were there any signs of syphilitic disease elsewhere? There were none that we could find, but there were two points which made us think it probable that the disease was of syphilitic origin: first, the record of the irregularities of the liver felt in 1912, probably gummatous deposits which had undergone absorption; and secondly, that in 1912, 1917, and 1918 a positive Wassermann reaction was obtained. Thus, the diagnosis was arrived at of a scarred gummatous liver with secondary enlargement of spleen, probably of congenital origin as there was nothing to point to acquired disease.

In this connection it is interesting to recall how closely cases of this kind may simulate the symptom-complex of "splenic anæmia," the splenomegaly, attacks of hæmatemesis and anæmia, overshadowing wholly the hepatic features of the case. To take an example: splenectomy was performed in a case, which was under the care of Dr. S. Coupland, thought to be splenic anæmia. Two years later the patient died with melæna, hæmatemesis, and ascites. At the autopsy a typical scarred syphilitic liver was found with varicosity of the œsophageal and rectal veins.

Thus, whether our diagnosis in this case is right or wrong, what I want to impress upon you is that the so-called "splenic anæmia" is only a symptom-group at present into which may get inserted clinical cases apparently identical and yet of dissimilar origin. Before coming to a diagnosis you must very carefully weigh all the pros and cons of the case, for although splenectomy for splenic anæmia in some cases is successful, yet it is a very serious operation in others. The spleen is large, the disease is very chronic; adhesions are often numerous, tough, highly vascular, and more than one case has succumbed to shock or uncontrollable oozing of blood after operation. Nevertheless we can say that permanent cure may follow removal even in long standing cases, but before advising the operation you must take every care to confirm the diagnosis.

(5) Another point of interest in the case which, so far as I know, is unknown, or at any rate very uncommon, in true splenic anæmia, is the occurrence of periods of pyrexia. There were none of these in the three months in 1918 when the patient was under my care, but in 1917 Dr. Evans tells us that they were a marked feature of the case, so much so at one time as to suggest lymphadenoma. In this disease bouts of intermittent fever of 10—14 days' duration are a recognised feature of some cases, and the same occurs in myelogenous leukæmia, but, of course, the blood count alone excluded the latter disease, and there was no evidence to indicate that the case was one of Hodgkin's disease. Other causes of splenomegaly, such as primary thrombosis of the portal vein, were raised only to be promptly knocked down again. The patient had not been abroad, and so none of the tropical splenomegalic conditions were thought to be applicable.

(6) *Treatment.*—The patient when in the

navy had been advised to have his spleen removed on account of the severity of the pain in the splenic region and of the danger of a recurrence of hæmatemesis, but he refused, and and he again told us he would not undergo operation. As we felt very doubtful of the case being one of splenic anæmia we did not try to dissuade him, especially, perhaps, because we felt that splenectomy of such a very large viscus would be a most hazardous undertaking for the reasons I have already referred to in discussing the operation. We therefore placed him upon a course of mercury and of increasing doses of potassium iodide which he has continued to take for the past six months with occasionally a short interval of freedom. Also between June and September, 1918, he was given six injections of novo-arseno-benzol.

His health is now satisfactory, and he is anxious to return to work. The Wassermann reaction remains strongly positive. The ultimate prognosis is not good. While the spleen remains so huge we cannot but fear that a recurrence of hæmorrhage may take place.

CASE 2.

Cerebral tumour with three years' history. Latent periods of $1\frac{1}{2}$ *and* 1 *year respectively during this time.*

The other case to which I want to draw your attention is a very instructive one. It is that of a woman of 40 years of age who was first admitted under my care in October, 1915; she remained in hospital until January, 1916. She was admitted in a semi-conscious state, which had gradually supervened in the course of some days, and it was accompanied by spasticity with weakness of the left arm and leg, and amblyopia. There were no signs of disease elsewhere. The optic discs were normal. She was fed by means of a nasal tube for about ten days to a fortnight. During this period she was occasionally sick for no obvious reason, and she apparently suffered from considerable headache at times. So far as the lethargic mental state and the amblyopia are concerned a gradual and complete recovery took place during her stay in hospital, but some weakness remained in the left arm. When the patient was discharged she appeared well except for the partial monoplegia. The Wassermann reaction of both the blood and the cerebro-spinal fluid was negative.

The next time our patient was admitted to hospital was in July, 1917. In the eighteen months since leaving the hospital the patient stated that she had suffered from occasional attacks of stiffness and weakness in the left arm and transitory amblyopia, and that a couple of months before readmission she had a "fit," followed by several more "fits" shortly before admission. After admission several violent general epileptiform convulsions took place, and after these had subsided she remained in a very dazed condition for some days. The weakness and rigidity of the arm were present as before, and she suffered from severe headache and projectile vomiting at intervals. There was no optic neuritis nor any fresh localising signs or symptoms. The mental condition rapidly improved, and although loss of power in the left arm remained, she was well enough to be allowed out of hospital in a month's time. She then remained out of hospital for one year, being admitted for the third time on July 31st, 1918. The history she now gave us was to the effect that for the past two months her headache had been getting much more severe, accompanied by occasional "fits." On admission the paresis of the arm was exactly as before, and there was slight loss of power in the left leg; no other signs whatever of organic disease existed. The plantar reflex was of flexor type, as it had been throughout. Mr. Ormond saw the patient and confirmed the absence of optic neuritis. The headaches were more frequent

and severe, also the vomiting, and the patient became once more very dull and lethargic. By the middle of August she became much brighter mentally, and towards the end of August the vomiting ceased for ten days. In September she got a great deal better, quite alert, walking about the ward, and anxious to return home, the sole reason for not allowing her to do so being that she was sometimes sick for no obvious reason. On October 3rd she had a "fit" ten minutes after her breakfast from which she never recovered consciousness.

The provisional diagnosis in October, 1915, was that of a tumour in the right cerebral hemisphere and mainly in the frontal area, although involving fibres to left arm and leg, probably a "glioma" as the most frequent variety in a person of her age. There was nothing to point to it being of syphilitic origin nor anything to suggest an abscess.

The feature of the case to which I wish specially to draw your attention is the long "latent" periods of absence of symptoms and the slow development of the lesion. In the three years during which the patient lived after her first admission to hospital there were two periods of 18 months and 12 months respectively in which she was in comparatively good health, at any rate sufficiently so to carry out her duties at home. Then more or less suddenly a flare-up occurred in the form of headache, vomiting, amblyopia and a stuporose lethargic state, and on the latter two occasions convulsions. The patient was more lethargic at the first admission than in the later ones, and she remained in this state so long that recovery seemed very improbable. There was no one more surprised by her complete mental recovery than myself, and if it had not been for the persistent slight weakness in the left arm we should have been more doubtful as to the correctness of the original diagnosis, and yet we know from the subsequent course of events that the tumour was present all the time.

Another point of interest is the suddenness of the fatal event, a feature well known in connection with cerebral tumours. This patient had been quite as well for some time before her death as she was before discharge in 1916 and 1917, the only warning that her condition was not so satisfactory being the occasional attacks of causeless vomiting.

The next point of interest is the absence throughout of optic neuritis, but this would not exclude tumour if there are other signs pointing to it. Headache is one of the most constant features of cerebral tumour, although, again, in her case there were long periods in which she was free from it, but when in hospital they were frequently very severe.

You will remember that the patient had "fits" on several occasions, and such general convulsions may occur with tumour in any part of the brain as the result of the increased intracranial pressure. As a rule convulsions are late features of the disease, but sometimes they are the earliest, so that a case may be diagnosed as "idiopathic epilepsy" when the convulsions are due actually to the presence of a tumour which has not up to that time given rise to localising signs or symptoms of its presence.

Transient amblyopia, which was present in this patient, is not at all uncommon in cerebral tumours.

Now I want you to look at the brain, and you will see that there is a soft, ill-defined tumour occupying a large part of the frontal lobe and extending back to the level of the right Rolandic fissure. The tumour has undergone cystic degeneration. I will read to you Dr. Nicholson's description of its histology and situation—

"The tumour was a glioma consisting of round, spindle, and branched cells with nume-

G. L. Cutts G. P. Lindsay G. B. Dowling W. F. Attwater G. H. Oriel A. E. Gawday W. M. Brown [illegible]
W. K. McKay C. L. Curle R. W. Warwick A. Y. Massouda C. H. Horwitz W. M. Brown W. R. Carling M. Cohen D. J. O'Meara

L. S. Debenham L. Lavine G. Richards P. J. Briggs W. A. Turner W. J. McB. Allan J. Van de Merwe C. T. Helsham C. G. Siggs L. Lyre W. G. Hay T. G. D. Bonar
R. B. P. Lansdown G. Hume A. R. Neckles O. Halstead F. W. Reitz G. McK. Thomas W. H. Cellier G. A. A. Bradnack R. S. Millar

GUY'S NIGGERS, CHRISTMAS, 1918.

rous larger nucleated cells embedded in a reticular ground substance."

And in describing the position of the tumour he says—

"The right cerebral hemisphere is slightly more voluminous than the left. About 1 c.m. in front of the middle of the Rolandic fissure there is a slightly prominent ill-defined patch, of a darker colour and softer consistency than the rest of the brain. This is found, on cutting into the right frontal lobe to be part of a large soft gelatinous, grey tumour, which occupies nearly the whole of its extent and has ill-defined edges. Its anterior part contains a large, smooth-walled cyst, occupied by limpid, orange-coloured fluid."

In relation to the slow development of the tumour and the long quiescent periods, it may be of interest to relate to you shortly the case of a man who was under my care in 1906. One day, in May, 1905, he noticed "while eating that his jaw became locked and he was unable to open it for two minutes." He felt dizzy, and was afterwards sick; also, that "his mouth was screwed round to one side and remained so for one and a half hours." From August, 1905, to January, 1906, he had daily attacks of similar character.

On admission in January, 1906, there was weakness of the grip of the left hand and left facial paresis. The optic discs exhibited an early neuritis. We saw the convulsions on many occasions, which consisted of a tonic contraction of the left side of the face involving especially the muscles of the angle of the mouth, the eyelids were half closed, and the head turned to the left, and the forehead wrinkled; clonic convulsions in these parts rapidly followed in which the left arm was also involved, and in some of the more severe "fits" the left leg also. No loss of consciousness at any time.

The patient was given large doses of potassium iodide, and about three weeks later the "fits" had become much less frequent and severe. At first he would have 40 or 50 "fits" in 12 hours.

The man was discharged on March 24th, not having had a "fit" for at least a week. He returned to his work for two and a half months feeling quite well except for an occasional twitching of the left arm and face. We thought we had made a mistake in our diagnosis of a cerebral tumour of gliomatous nature, and that it was possibly a gumma which was undergoing absorption. However, on June 7th he came back complaining of very severe headache, worse than he had ever experienced, and the paresis returned.

He died ten days later, and at the autopsy a large glioma was found with recent hæmorrhage into its substance. The tumour occupied the greater portion of the right frontal lobe, extending back into the motor area and reaching the surface just behind the commencement of the Sylvian fissure; it measured $2\frac{1}{2}$ inches in its longest diameter. On histological examination it proved to be a sarcoma.

Thus, here again is an illustration of the fact that although a tumour was present for more than nine months before the patient came under our care, and that when he first did so more than 50 convulsive attacks occurred daily, yet the symptoms disappeared, the "fits" ceased for two and a half months, and the man went back to his work. Then there was a hæmorrhage into the tumour, causing a return of his symptoms, which shortly led to the patient's death.

Change of Address.

Dr. R. Quesada, Royal Infirmary, Sheffield.

2nd Lieut. A. R. Cox, Machine Gun Corps, Brighton, to Guy's Hospital, S.E. 1.

Guy's Hospital Physiological Society.

A MEETING of the above Society was held on December 12th, at which Dr. Laidlaw kindly took the chair.

After the private business had been discussed Mr. V. Braithwaite read an able and illuminating paper on the Pineal Gland, assigning to that body the functions of an internally secreting organ, and even going so far as to define the methods by which this secretion was used, in the general metabolism of the body, and those organs and physiological phenomena which were influenced by the same.

The evidence of secretion — based upon the following facts (1) Differentiation of structure involves division of labour; (2) the pineal body is said to contain four different varieties of epithelium abundantly supplied by the sympathetic system; and (3) at the time of involution of the pineal, about the seventh year, an appreciable rise in the normal development of the child takes place—was systematically and thoroughly investigated.

Mr. Braithwaite went on to suggest that it was a shame to load the thymus, a piece of perfectly frank lymphoid tissue, with the responsibility of controlling the anti-puberty development of the genitalia; and maintained that the pineal gland was responsible for this control. Furthermore, that the pineal secretion might very well be the causative factor of second dentition.

The subsequent discussion was very well maintained, causing much diversion because of the manysidedness of the arguments put forward.

Mr. Massie, representing the anatomist's and morphologist's view, maintained that the pineal body was nothing more or less than the vestigial remains of an invertebrate eye. It was illogical, he averred, to suggest that a structure, morphologically an eye, should suddenly be metamorphosed into a full-fledged internally secreting organ.

Dr. Pembrey physiologically maintained that the pineal body, being developed from the fertile ovum, was an internally secreting gland in that every cell of the body is such an organ. He deplored the lack of receptivity in the minds of everyone who was not a physiologist, and saw no reason why the pineal should not function as Mr. Braithwaite suggested.

The chairman, Dr. Laidlaw, representing pathology and medicine, considered Dr. Pembrey's view was extraordinary in that he assumed a secretory function to the pineal body. Physiologists, he asserted, could explain anything away, but it was his opinion that the Pineal had no function whatever, and he challenged anyone to bring definite evidence to the contrary.

The suggestion having been made the Pineal might be the seat of the soul (Paracelsus, 1500). Mr. Maizels aptly remarked that, were such the case, it would have atrophied long ago!

The chairman then put it to the vote as to whether it had been established that the pineal body possessed an internal secretion or not, and the "noes" had it by 27 votes to 4.

The meeting closed with a hearty vote of thanks to Dr. Laidlaw for taking the chair.

Papers by Guy's Men.

Herbert French, M.D., F.R.C.P., Lieut.-Col. R.A.M.C.: Three clinical lectures on a series of small points. Lecture III.—*Clinical Journal*, Dec. 7th, 1918.

W. Johnson, Major R.A.M.C. (S.R.): Hysterical tremor.—*B.M.J.*, Dec. 7th, 1918.

E. J. Spriggs, M.D. Lond., F.R.C.S. Lond.: The examination of the verimiform appendix by X-rays.—*Lancet*, Jan. 18th, 1919.

Percival P. Cole, F.R.C.S. Eng. (in collaboration with Charles H. Bubb, L.D.S.); Bone grafting in re-united fractures of the mandible.—*B.M.J.*, Jan. 28th, 1919.

A Fall from a Cliff 320 feet high without Fatal Injuries.

BY PHILIP TURNER, M.S., F.R.C.S.

IT will be well first of all to give some description of the locality where this remarkable accident happened. The hospital camp was situated on a level stretch of ground at the top of a chalk cliff 300—350 feet high on the French coast. As is commonly the case with a chalk cliff, the face is practically perpendicular though towards the town, where the plateau recedes from the beach and falls rapidly down to sea level, there is a steep slope formed from old fallen debris, concealing the foot of the cliff and rendering it possible to scramble up for 100—150 feet. At the site of the accident this slope has gradually disappeared, for here the cliff has reached the beach, and any fallen debris is rapidly removed by the action of the waves. The face is, at this spot, perpendicular from top to bottom, but about half way down there is a small projection, covered with a little gravel and vegetation, which can scarcely be called a ledge for it would be quite impossible to obtain a foothold on it. A stone dropped from the top would probably strike the ledge and bounce from it to the beach. The face of the cliff is decidedly irregular, there being a series of small bays and promontories. The site of the fall was in one of these bays, which may be of importance in explaining the comparatively trivial nature of the injuries. At the base of the cliff is an ordinary stony beach with chalk boulders and a little gravel debris. At the top of the cliff there is a path very imperfectly protected by a low wire fence in indifferent repair, only a few feet from the edge which is very irregular and dangerous. The path is separated from the hospitals by a barbed wire fence, and is "out of bounds." As regards the actual height, official French maps give, for a locality about 200 yards away of distinctly lower altitude, a height of 109 metres or, roughly, 350 feet. As the sea, even at the highest tides does not quite reach the base of the cliff at the place under discussion, the vertical height from the beach must be appreciably less and may be fairly estimated at not less than 320 feet.

At 9 a.m. on December 9th, 1916, I was informed that a man had fallen over the cliff, that he was alive, and was being brought to the hospital. When first seen he was not unconscious, but was restless and delirious, and could not be got to answer questions. He was in a filthy mess, his head and face being covered with blood, chalk and gravel, and his clothes, including a service great coat, being soaked with water and soiled with the same materials. There was no smell of alcohol, and it was practically certain from the way in which he moved his limbs that there was no fracture of any of the long bones. The man was soon identified as a Private in a Canadian regiment who had been admitted some time previously into a neighbouring hospital with a slight wound of his arm. This had healed, and he had been discharged to the Convalescent Depôt in the same camp, where he had last been seen or heard of at 5.30 p.m. on the previous day. When he had been put to bed and cleaned up, his injuries were investigated. There were about ten scalp wounds, four of which extended down to bone, and in one of these in the right frontal region a fissured fracture of the skull of uncertain extent could be made out. There was no depressed fracture, no paralysis, the pupils were normal, and though there was bleeding from the nose, there was no hæmorrhage from either external auditory meatus. There was a large wound of the right knee where a flap of superficial tissues was torn up on the anterior, external, and posterior aspects of the joint opening up the popliteal space, and, as was subsequently found, the knee-joint also. There was no evidence of any thoracic or abdominal injury, and though there were a number of superficial cuts and

contusions, there was no fracture of any of the limb bones. The head was shaved; all the wounds were cleaned and dressed, and the injured leg put on a back splint. It was thought that there was probably an extensive fracture of the base of the skull, and the condition appeared so grave that little hope was entertained of his recovery.

After three days the restlessness and delirium had diminished, but the patient was still unable to answer questions or to give any account of the accident. The wound of the leg had become septic, so an anæsthetic was given, the wound was opened up and a piece of chalk removed from the popliteal space. The knee-joint was found to have been opened on the outer side, so the joint was washed out, the damaged portion of capsule and synovial membrane, was excised, and the rent sutured. A counter incision for drainage was made at the back of the thigh and the leg put up on a Thomas's splint.

The subsequent progress was remarkably good. The scalp wounds all healed without suppuration, and the only sign of any intracranial trouble was that on December 17th slight left facial paralysis was noticed with inequality of the pupils, the right being the larger. No further symptoms were noticed, and even these cleared up in the course of a week or ten days. The wound of the knee also did well, rapidly cleaning up without infection of the joint. A considerable amount of swelling about the lower extremity of the femur, however, persisted, and an X-ray plate taken some weeks later showed what appeared to be a fissured fracture of the external condyle without solution of continuity of the bone. An X-ray examination of the skull showed no definite injury. The mental condition also improved, and after a week or ten days he was quite conscious and able to answer questions intelligently. He could remember being wounded, being admitted to hospital, and being in the convalescent depôt, and even what he did there on the afternoon of December 8th, but he maintained that he had no recollection of leaving the camp, of what he did on the night of December 8th, or of how he was injured, or, indeed, of anything until he found himself in the hospital.

This attitude remained unaltered during the whole time—nearly three months—that he was kept in the hospital, and I believe it to be perfectly genuine. He naturally heard some gossip about what had happened to him, and after a time, when questioned about the accident, he would, after repeating that he remembered nothing until he found himself in hospital, add, "You know, sir, they tell me that I fell over the cliff, but I don't believe that it's possible."

When I first saw the man after admission I considered it more probable that he had been assaulted on the beach, or had had a fall while scrambling up the slope already described than that he had fallen from the top of the cliff to the beach. This was, however, completely cleared up at a subsequent inquiry. Some French labourers were at work on the beach at the time and two of them noticed a falling object against the white surface of the cliff, saw this strike and bounce from the ledge already described, and hardly realised that it was a man until he fell on the beach about 50 yards from where they were working. This was at 8.30 a.m., and they at once gave the alarm, with the result that an ambulance was sent for and the man admitted by 9 a.m. What never was cleared up, but remained a mystery and a subject for speculation was the series of events between 5.30 p.m. on December 8th, when he was last seen, and 8.30 a.m. on December 9th. It was a stormy, wet, wintry night, when certainly no one would choose to be out if it were possbile to have a roof over one's head, and that he had been out all night seemed certain from the sodden condition of his clothes. It appeared highly improbable that he could have gone to the neighbouring town for drink and stayed there all night, for there was no odour of alcohol about him on admission, and it is unlikely that he could have avoided the military police both on leaving and returning to the camp. Besides this the amount of money in his possession on the previous day

was known, and this corresponded with the amount found on him on admission.

While in hospital he was visited by a brother who lived in England, who informed us that there was no history of epilepsy or of any mental trouble. Also that he had written home regularly and that his letters were always cheerful in tone, including one written the day before the fall. It was noticed, too, that when he had recovered from the shock and delirium he was quite bright and cheerful, and, though carefully observed, no mental or nervous peculiarity was detected. His comrades, including those who were with him up to the time that he disappeared from the recreation hut of the convalescent depôt at 5.30 p.m. on the evening of December 8th, gave a similar account, viz., that he was quite content and happy and that he was looking forward to rejoining his unit. There was no mention of any "shell shock" or other similar condition on his field medical card, and nothing suggesting this had been noticed either at the hospital where his wound had been treated or at the convalescent depôt.

With regard to the amnesia, the question arises as to whether this was the direct effect of the injury, or whether the loss of memory, due perhaps to some unrecognised mental or hysterical disturbance, the result of having been under fire, was the primary cause of his spending an inclement winter's night aimlessly wandering about the countryside and straying over the cliff edge on the following morning. The general impression was that the latter was the more likely, and that the loss of memory, whatever its explanation, was the primary condition. The actual fall might have been due to either a murderous attack, an attempt at suicide, or an accident. With regard to the first there was absolutely no evidence of this; there was no robbery, and the site of the fall, though deserted on account of the season and weather, was within view of several parts of the camp, and hence was unlikely to be chosen for such an attack. The second seemed very improbable with the absence of any mental symptoms both before and after the injury and the lack of any evidence of threats to do away with himself. The third is the most probable, and the broken irregular sloping edge rendered slippery and treacherous by the rain make it easy to understand how such an accident could happen to a man aimlessly wandering, or even possibly sleeping, in such a dangerous place. About nine months later I received a report as to this man's condition on his discharge from hospital in England. The large wound of the leg had healed, but there was still a good deal of swelling about the lower end of the femur, and the knee-joint was ankylosed. He was however, able to walk. The mental condition appeared to be normal, but he still had no recollection of his terrible fell or of the events which occurred immediately before and after it. He was about to appear before a board with a view to discharge from the army.

I know of four other cases of falls from this cliff. In three of these there were most extensive fractures with severe internal injuries, death in each being probably instantaneous. In the fourth, from a much lower height where the vertical fall was about 50 feet with a subsequent fall down a steep slope of about 100ft., there were also extensive injuries, but the man lived for some hours after admission to hospital.

How is one to explain the comparatively slight nature of the injuries in this case? Certainly to look at the cliff at this spot either from above or below makes one marvel that anyone could survive after such a fall on to a stony and boulder-scattered beach. One possible explanation is that there was at the time a fairly strong wind blowing in from the sea, and I have often noticed under these conditions that there is a very strong updraught, especially in these bays in the cliff face. It is just possible that such an updraught might have got in beneath the heavy service great coat and exercised sufficient "parachute" action to considerably break the fall.

The only case comparable with this that I remember to have read of occurred at Lulworth Cove, and is probably familiar to those who have visited this picturesque spot on the Dorset coast. It is thus described by Sir Frederick

Treves in "Highways and Byways in Dorset." "The cliffs that shut in the cove on the land side are steep and terrible. On the beach at the foot of the highest precipice is a board with this inscription on it: 'This marks the spot whereon E. H. L., aged 11 years, fell from the summit of the cliff, a descent of 380 feet, September 7th, 1892. She miraculously escaped without sustaining lifelong injury.' Any who look up from this spot to the fringe of grass which crowns this appalling wall will never for a moment credit that a child can have fallen from a height greater than that of St. Paul's Cathedral without having been mangled to death. I did not actually see the poor girl fall, but I was on the beach when she was brought to the coastguard boathouse, where I was able to attend to her terrible injuries. She came down with her back to the cliff. Her clothes were torn into strings, and it would appear that the catching of her garments on the rough face of the precipice, together with the circumstance that certain slopes and ledges were encountered in her descent, help to explain the incredible fact that she escaped with her life, and still more happily without permanent ill effect."

Though the cliff at Lulworth Cove is decidedly higher it is much less perpendicular than the one described above which, as has been pointed out, is practically vertical.

It will interest Guy's men to know that not only did "E. H. L." escape without permanent ill effect, but that in after years she trained as a nurse at Guy's Hospital.

PHILIP TURNER.

A Case of either Reflex Anuria or Infective Ascending Pyelonephritis (Surgical Kidney.)

E. B., æt. 47, admitted for several small urinary fistulæ at junction of scortum and perineum.

Prior to the anæsthetic he showed great fear, and the induction was difficult as he obstinately refused to breathe and swallowed air whenever he could. C_2E_3 and Chloroform were used.

Sir Alfred Fripp operated at 6 p.m. on the 7th instant. The fistulæ were scraped and a sound passed through a fibrous stricture.

As he showed great restlessness, $\frac{1}{4}$ gr. of Morphia was injected at 11.15 p.m. At 2 a.m. on the 8th instant his pulse was 92, at 6 a.m. 166, at 8 p.m. his radial pulse could not be felt; 1/16 gr. of Strychnine was injected; $\frac{1}{2}$ oz. of Spiritus Vini Gallici every four hours was ordered, but this frightened him and caused him to vomit. Later he was given xxx min. of Aether in Brandy, but on placing the phial to his lips he tried to vomit and eventually succeeded. One grain of Camphor in vi min. Olive Oil was injected, then 1/22 gr. Strychnine four-hourly, and as the circulation was so bad xv. min. of Pituitary Extract was injected.

On the 9th instant the temperature was 95°, and still no pulse could be felt in the radial artery though his body was warm and face a good colour. He resisted and returned anything administered per rectum. As no urine had been passed, his bladder was examined. There was no pain on pressure over the hypogastrium; it was resonant to percussion and the abdominal wall not full over this area. Catheterisation also showed an empty bladder. 1/250 gr. Strophanthin four-hourly was given with a view to raising the blood pressure and causing a secretion of urine; also he was infused with normal saline solution.

Early on the 10th instant, as no urine had been passed since before the operation, 1/10 gr. of Pilocarpine Nitrate was injected and patient wrapped in hot blankets, and later this was repeated, causing a moderate perspiration. Draughts of Potassium Citrate were given, which he took, being the first time he had taken anything per oram. In the afternoon a rapid flicker of the pulse was just palpable at times, and respirations rose to 48 and later to 60. He was dry

cupped over both renal areas alternately by the method of exhausting the air by burning spirit saturated absorbent paper in the glass, but as this was not satisfactory, Bier's loin apparatus was used with success. A few drops of urine were now passed into the bed. This cupping glass was left on both loins at intervals of twenty minutes for two hours. Slight surgical emphysema was observed over the left thoracic parieties. This has not been explained. At 5 p.m. his temperature shot up to 104 in the axilla, respirations 60, pulse still absent, face becoming cyanosed. Blood was taken for chemical examination, and a pint of 25 per cent. solution of glucose was about to be injected into the median basilic vein, as "sugar solutions are powerfully diuretic" (Thompson-Walker), when the patient died.

No rigors had occurred. Once only a few drops of urine were passed. The urine before operation gave a negative test for albumen and sugar. After the operation both eyes were examined by the ophthalmoscope, but the vessels appeared small and the discs pale, probably because the blood pressure was so low. His pupils were always small, and neither dilated in the dark nor contracted to vivid light. The blood taken contained nine times the normal amount of urea.

The post-mortem examination revealed the bladder mucous membrane red in appearance from congestion; the right kidney had a necrotic mass about one square inch in size in the cortex surrounded by a narrow pink zone. The spleen showed recent perisplenitis and several areas of red softening. The left kidney, ureters, and other viscera were normal.

This is a case of either reflex anuria or an ascending pyelonephritis due to blood-borne bacteria.

I am indebted to Sir Alfred Fripp for permission to publish this case.

R. S. M.

Guy's Hospital Dental Society.

A Special Meeting of the Society was held on December 19th in Class Room II. at 5 p.m. to elect officers for the remainder of the present Session. Mr. J. Rhys-Herbert presided. The following officers were elected :—

President—Mr. M. F. Hopson.

Vice-Presidents—Mr. F. Bocquet Bull, Mr. F. N. Doubleday, Mr. J. Joffé, Mr. F. J. Pearce.

Hon. Sec. and Treas.—Mr. J. Rhys-Herbert.

Committee.—Mr. S. H. Coplains, Mr. J. W. Greenwall, Mr. D. K. Gaskill, Mr. C. G. Atkinson, Mr. W. H. Willis.

Dental Correspondent—Mr. A. H. Grieve.

The date of the next meeting is on Friday, February 7th, at 8 p.m. in the College Smoke Room. *Subject*—"National Reconstruction and its relation to the Dental Profession." Papers will be read by Mr. S. H. Coplains and Mr. J. W. Greenwall. Chairman, Mr. M. F. Hopson.

The Twentieth Annual Dinner of the Society will be held on Saturday, May 10th, at the Connaught Rooms, Great Queen Street, W.C. Further particulars will be published later. Any matters of dental interest will be gladly received by Mr. A. H. Grieve, the Dental Correspondent.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I am interested in the case of Friedländer's Bacillus ? reported by G. B. D. in your issue of the 11th instant. I am afraid I am very stupid and cannot quite follow the autopsy.

I always thought that Friedländer's Bacillus was the diplococcus of pneumonia, and no mention is made of the lung condition except ante-mortem. Had the case been called Friedländer's disease, that is "endarteritis obliterans," it, that is, the autopsy would have fitted well. Age 74, removal of prostate, condition of the circulatory system, ante and post-mortem, seems enough to explain death. The cultivation of a bacillus from the spleen might be a part of something else which produced the rigor and hastened death. I should be glad if G.B.D. would elucidate and put me right. I may be a bit behind the times.—Yours, F. B. JUDGE BALDWIN.

Ward Concerts.

MARTHA—LAZARUS.

The concert was held in Martha ward on Tuesday, 31st December, 1918. The ward had been very prettily decorated by sister and the nurses. The decorations consisted of oranges and lemons. In one part of the ward a number of dolls had been dressed up and arranged to illustrate the old game of oranges and lemons.

The concert was commenced at 3 30 by a Mr. Henshall, who had arranged for a very varied and talented number of artistes to appear, and so provided ample amusement for all.

There was a short interval, in which tea was served. After tea the concert was continued and kept everyone interested to the end. Mr. Henshall and his party were given a very hearty vote of thanks and three cheers in a truly Guy's fashion.

Everyone was very keen to finish up with a few nigger songs and choruses, and so this was done.

This everyone will regret to hear was Sir Arbuthnot Lane's last Christmas at the hospital. Three cheers were given for Sir Arbuthnot and Lady Lane, and also for Sisters Martha and Lazarus. At 6 p.m. "God save the King" was sung, and this brought a most enjoyable afternoon to a close.

Honours.

K.C.M.G.

Col. J. Atkins, C.M.G., A.M.S.

K.C.B.E.

Col. W. H. White, R.A.M.C.

C.B.

Temp. Lieut.-Col. H. L. Eason, C.M.G., R.A.M.C.

C.B.E.

Col. W. G. Beyts, A.M.S.

O.B.E.

Lieut.-Col. (Temp. Col.) H. P. W. Barrow, C.M.G., D.S.O., R.A.M.C.

Temp. Capt. (Act. Major) W. G. Mumford R.A.M.C.

Temp. Capt. J. A. Delmrge, R.A.M.C.

D.S.O.

Major (Act. Lieut-Col.) J. Evans, R.A.M.C., T.F.

Capt. (Act. Major) L. Milton, R.A.M.C.

Capt. (Act. Lieut.-Col) J. Young, R.A.M.C., T.F.

Capt. (Act. Lieut.-Col.) L. D. B. Cogan, R.A.M.C.

M.C.

Act. Major F. E. W. Rogers. R.A.M.C., T.F.

Temp. Capt. J. G. Jones, R.A.M.C. (Mesopotamia). Although exposed to heavy and continuous shell fire throughout the day he continued to dress the wounded in the gun line, thereby alleviating much suffering and saving many lives. His courage on all occasions has been most marked.

Temp. Capt. D. H. A. Galbraith, R.A.M.C. (Mesopotamia). He was wounded in the head whilst attending to a wounded officer, and though in great pain he continued to carry out his duties for the remainder of the day with zeal and determination.

Lieut. (Temp. Capt.) W. D. Newland, 92nd Field Ambulance, R.A.M.C. Under conditions of open warfare he collected a number of wounded for evacuation. The place came under heavy shell fire due to a number of tanks passing close to the posts. With great courage and devotion he remained with the wounded until he was able to clear them all, although the fire was so heavy that all troops had to leave the immediate neighbourhood.

Mentioned in Despatches.

A.M.S. (STAFF).

Capt. (Acting Major) M. Coplans, D.S.O.

Appointments.

R.A.M.C.

To be Acting Major—Capt. O. R. L. Wilson.

Temp. Lieut. to be Temp. Capt.—T. A. Matthews.

Officers relinquishing their Commissions.—Temp. Major J. B. Howell, Temp. Capts. E. A. Miller, E. C. Roberts, W. A. Young, R. D. Smedley.

Territorial Force.

Capt. (Acting Major) J. Walker relinquishes his acting rank on ceasing to be employed.

Major W. R. E. Williams relinquishes his commission on account of ill health.

3rd General Hospital—Capt. W. B. Secretan is seconded for duty with the Reading War Hospital.

T. F. Reserve.

Capt. W. L. Hibbert from Home Counties Clearing Station to be Captain.

R.A.F.

Medical Board.—A. G. H. Moore is granted a commission as Captain.

Specialities.

GENATOSAN, LIMITED, 12, CHENIES ST., LONDON, W.C.1.

Aspirin (acetyl-salicylic acid), is recognised as the most valuable of the salicylic group of drugs. The virtue in its preparation is the elimination of every trace of free salicylic acid and free acetic acid. But until lately this has been found very difficult to accomplish.

Genatosan, Limited, have, however, now prepared acetyl-salicylic acid in a particularly pure state, to which they have given the name "Genasprin."

This preparation can stand upon its own merits, as its acknowledged purity is sure to make it widely appreciated.

Births.

HIND.—At Roxeth House, Stoke-on-Trent, to the wife of G. R. Hind, M.B., B.S.—a daughter.

LLOYD.—On the 14th inst., at Acle, Norfolk, to Dr. and Mrs. F. E. Lloyd—a daughter.

TANNER.—On Jan. 12th, 1919, at Nursing Home. Worthing, the wife of Capt. W. E. Tanner, R.A.M.C., of a son.

G. P. L.

GUY'S HOSPITAL GAZETTE.

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Passim.

ON two occasions during the last few days the quiet routine work of the hospital has been interrupted by a burst of cheering and the singing of "For he's a jolly good fellow," which issued from the Colonnade steps. Thus did the Hospital bid farewell to its late Senior Surgeon Sir Arbuthnot Lane and Senior Physician Sir W. Hale White, who are now promoted to the Consulting Staff. The rule of retiring from the active Staff at the age of sixty has been in abeyance during the war, for in both cases the generous offer of extended services was accepted by the Hospital authorities.

It was very gratifying to see many old Lane H.-S.'s accompanying Sir Arbuthnot in his last round, where he demonstrated on selected cases in Martha and Lazarus, particularly those in which he had removed the large bowel for stasis. After the round the company adjourned for tea kindly provided by Sister Martha. Then Mr. Thomas, the last Lane H.-S., and Mr. Mollison aptly expressed the sincere regret which the Hospital felt at the loss of one so distinguished, coupled with a sense of pride that a name that is world-famous can be claimed as a "Guy's man." Sir Arbuthnot briefly expressed his thanks: "During 46 years at Guy's it has been my privilege to be associated with the most able men. I have been fortunate in having as House-Surgeons some of the best men England can produce. The future of surgery lies in their hands and I am quite content to leave it there."

Sir W. Hale-White's last round took place on Monday, February 3rd, when a large gathering turned up in Addison ward, animated by a common feeling of admiration for their departing chief. There was a good variety of cases, and the characteristically quiet and impressive round was greatly appreciated by all who were fortunate enough to be present. Tea was provided for the visitors by Sister Addison at the conclusion of the round, after which our genuine sense of loss was voiced by Mr. Halstead and supported by Capt. C. P. Symonds, who fitted the occasion well by a story illustrating the good reputation Guy's men have established abroad. Sir Hale White, evidently not unmoved by the thought that this was his last round after 44 years at Guy's, briefly returned thanks.

These two familiar faces will be sorely missed in the Hospital, but we have left behind two memorable influences to add to those of the great ones that pass on from Guy's. We wish to both many more happy and useful years in

which reputations may be added to, and venture to hope that as many as possible of the Hospital functions will be graced with their presence.

The same experience will produce different impressions in different minds, and Sir Hale White is recorded to have said, "Medicine is largely a matter of impressions." After witnessing the two foregoing events our reflection was that although it is not for everyone by a distinguished career to bring renown to the Hospital, yet it is possible for everyone to work in a small way for the good of the Hospital, and not entirely for personal ends, and in this matter we should do well to follow the example of some of our great predecessors whose love for the Hospital was both the inspiration and the reward of their labours.

WE should like to offer our heartiest congratulation to Mr. E. G. Slesinger who has been appointed to deliver the Hunterian Lecture on Monday, February 17th, at the Royal College of Surgeons. The subject of the Lecture will be "The early Treatment of Compound Fractures and other Severe Injuries of the Upper Limb." We hope that the opportunity of hearing the lecture will be taken by as large a number of Guy's men as possible.

THE sincerest thanks of the Hospital are due to Messrs. Ash & Co. for their generous gift of Guy's Hospital Christmas Greeting Cards. The sum realised from the sale of these cards is more than £27, a handsome donation to the Hospital Funds.

THE Guy's War Memorial Fund has now reached a total of more than £3,000. The following additional subscriptions have been received since the publication of the last list:—

	£	s.	d.
D'Arifal, A. C., L.	3	3	0
Child, S.	1	0	0
Page, H. M.	10	0	0
Davies, M.	5	5	0
Ashwin, H.	2	2	0
Delbruck, R. E.	5	5	0
Claxton, E. J.	2	10	0
Forman, E. Baxter	5	5	0
Adams, R. R.	1	1	0
Carlill, H.	3	3	0
Chaning-Pearce, Miss Elinor	5	0	0
Clapham, Crockley	2	2	0
Crofts, A. Douglas	3	3	0
Bunney, J. Brice	1	1	0
Peregrine, H. L.	1	1	0
Hardenberg, E. J. F.	10	10	0
Harrison, Gen. Sir Richard	5	5	0
Daldy, A. M.	5	5	0
Shattock, C. R.	5	5	0
Morgan, R. C.	1	1	0
Cheesman, J.	2	2	0
Todd, A. H.	10	10	0
Mutch, R. S.	2	2	0
Howe, J. Duncan	2	2	0
Fagge' Mr. & Mrs. C. H.	52	10	0
Rowlett, A. E.	1	1	0
Hodgkinson, R. J.	2	2	0
Collier, H. W.	2	2	0
Hind, G. R.	5	5	0
Wain, D.	3	3	0
Jacobson, W. H. A.	10	10	0
Cole, A. C.	21	0	0
Kemp, J. Wallace	1	1	0
Cuff, R.	1	1	0
Ballard, R. P.	2	2	0
Beale, Clifford	5	5	0
In Memory of S. S. B. Harrison	5	0	0
Roberts, T. W.	1	1	0
Daniell, S. H. S.	5	0	0
Zorab, A.	5	0	0
Farnfield, W. W.	2	2	0
Hunt, G.	5	0	0
Marsh, A. P.	2	2	0
Rowell, Miss Ellis	3	3	0
Anonymous (per Miss E. Russell)	12	12	0
Wheeler, F. J.	1	1	0
Hayes, Reginald	5	5	0
Smart, H. Douglas	1	1	0
Wallace, F. Herbert	5	0	0
Tipping, H.	2	2	0
Collington, F. A.	5	5	0
Severn, A. G. E.	1	1	0
Horsley, L.	2	2	0
Horsley, H.	1	1	0
Dawson, R. B.	5	5	0
Malpas, D. D.	2	2	0
Elliot, H. H.	5	5	0
Barrow-Clough, J. R.	10	10	0
Cooper, J. Sephton	2	2	0
Burrell, L.	1	1	0
Knight, J. T.	1	1	0
Evans, H. L.	2	2	0
Eastes, Thos.	1	1	0
Barrs, A. G.	5	5	0
Croft, L	10	10	0
Tulk Hart, E. J.	1	1	0
Girling, C. J.	1	1	0
Blaker, N. P.	5	5	0
Blake, E. W.	5	0	0
Ryle, J. A.	2	2	0
Langridge, F. W.	2	2	0
Trubridge, L. W.	1	1	0
Bradbury, J. C. O.	1	1	0
Fison, A. H.	5	0	0
Westman, C. J. F.	1	1	0
Edwards, Dr. & Mrs. C. D.	5	0	0
Elliott, Edgar	10	10	0
Goodhart, G. W.	10	10	0

Hitherto there has been practically no response on the part of students. It is proposed to start a special fund for present Guy's men, and it is hoped that a really substantial sum may be collected in this way. The scheme should be fully developed by the date of our next issue and we hope by that time to be able to publish a first list of subscribers.

We have to congratulate ourselves on really good all-round results in the Final Conjoint Examinations. Out of thirty-three entries for all subjects there have been only five failures. These figures speak volumes for the Teaching Staff who have been working under considerable difficulties.

Our heartiest congratulations to Mr. Grace, who has recently gained the diploma M.R.C.P.

For the first time almost since the war began there is practically a full complement of qualified men to fill the qualified posts. Their absence has been rather severely felt in the past in some Departments, notably the Surgery and Out-Patient Departments, where the responsibility has for some years fallen mainly upon the shoulders of one qualified O.P.O. and four Assistant Casualty Officers. The greatest credit is due to those who have held these posts in the past, for the admirable way in which the work has been carried out in the face of difficulties which would have been regarded as insuperable before the war.

The greatest pleasure is felt at the election of Mr. A. A. Forty as President and Mr. G. T. Helsham as Vice-President of the Residents. We heartily congratulate them, and feel assured that by them the traditions of the Hospital will be ably carried on during the forthcoming three months.

We have pleasure in announcing that Miss Swift (Matron of Guy's Hospital from 1901 to 1909) has been appointed a Dame Grand Cross of the Order of the British Empire.

Since 1914, Miss Swift's valuable experience and service have been devoted to the cause of the British Red Cross Society as Matron-in-Chief of the Trained Nurses' Department.

Among the many congratulations she has received upon the bestowal of the Order, we are sure she will feel none are more sincere than those expressed by all who knew her as Lady Superintendent of the Guy's Trained Nurses' Institution and Matron of the Hospital.

We are pleased to announce the following Honours for Guy's Nurses. Royal Red Cross (2nd Class):—

Miss F. Broome	...	Q.A.I.M.N.S.R.
„ M. E. A. Colston	...	„
„ N. Connolly	...	„
„ C. Gerrard	...	„
„ F. M. Hepburn	..	„
„ F. A. Morgan	...	„
„ A. M. Lithgow	...	„
„ G. L. White	...	B.R.C. Soc.
„ E. Wood	...	T.F.N.S.

Appointments.

R.A.M.C.

Temp. Lieut. to be Temp. Capt.—C. Dean.

Officers relinquishing their Commissions.—Major H. E. Grellett relinquishes his Commission and retains the rank of Captain.

To retain the rank of Captain.—H. C. Rice, J. L. Johnston, T. A. Matthews, F. S. Adams, F. Barnes, S. C. H. Bent, H. Walker, P. W. L. Camps, J. Cameron, S. S. Brook, L. Bromley, C. A. R. Gatley, T. J. Bennett, H. M. Reeve.

Capt. A. G. H. Moore relinquishes his rank on transfer to R.A.F.

Dental.—Temp. Lieut. P. R. Helyar, attd. R.A.M.C., relinquishes his Commission.

R.A.F.

Lieut.-Cols. to be Lieut.-Cols., Grade A.—H. Cooper.

L. B. Stringer, Temp. Surg. R.N., is granted a temporary commission as Captain.

Territorial Force.

Major (Acting Lieut.-Col.) J. Evans relinquishes his acting rank on ceasing to command a Field Ambulance.

Capt. to be Acting Major whilst specially employed.—J. H. Donnell.

T. F. Reserve.

Capt. A. V. Maybury, from 3rd Wessex Field Ambulance, to be Captain.

The Surgery of Gastric Ulcer.

CLINICAL LECTURE BY F. J. STEWARD, M.S., F.R.C.S.

GENTLEMEN,—I may say, at the outset, that I had hoped to give two lectures on this subject, and so treat it fairly fully, but owing to influenza I am reduced to one lecture. I intend, therefore, to cut out reference to perforated gastric ulcer, and deal with the other aspects only.

First, a few general points regarding gastric ulcer before attacking the subject of the lecture.

Ulcer of the stomach may be either single or multiple. In most cases a single ulcer is present. With regard to situation, it is well to remember that the tendency is for an ulcer to occur mostly in the neighbourhood of the lesser curvature, and more often to the right of that curvature, that is to say, towards the pyloric portion of the stomach, the incidence becoming less and less as you pass away from the pylorus and away from the lesser curvature.

But any part of the stomach may be affected by ulcer, and I shall presently have occasion to describe a case of ulcer which affected the posterior wall of the fundus of the stomach.

Given a gastric ulcer situated in some part of the stomach, let us now consider what may happen to it.

1. First, there is no question that a gastric ulcer may *heal*, either with or without treatment. The grounds for that statement are these. In collections of observations made on the stomach *post-mortem*, far more scars of healed ulcers are found than open ulcers; hence the presumption is that many ulcers heal. Then there is the result of medical observation. Many physicians hold very strongly, from their experience that a large proportion of gastric ulcers heal as the result of treatment. I do not attach great importance to figures, but I may mention that Lenhartz claims that more than 75 per cent. and Bassler that 95 per cent. of all cases of gastric ulcer are cured by medical treatment. The case is better put in general terms, I think, namely, that the opinion of those who ought to know—those who have given a great deal of time and attention to the subject—is, that a large proportion of gastric ulcers heal as the result of medical treatment.

2. Secondly, a gastric ulcer may *perforate*—I must mention that, although, as I have said, I am leaving out the consideration of perforated gastric ulcer. Many perforate and give rise to the "acute abdomen."

3. The third thing which may happen is, that the ulcer may *bleed*. Bleeding from a gastric ulcer is extremely variable in type. For instance, a patient with gastric ulcer may suddenly get a hæmorrhage which may be fatal in an hour or two. At the other end of the series are cases in which patients have more or less continuous slight hæmorrhage, which is only recognised as occult blood in the fæces. Between those extremes one may meet with almost any degree. The common occurrence, perhaps, is sudden hæmorrhage, the patient is attacked with faintness, and shortly afterwards brings up a quantity of blood. As a general rule, the hæmorrhage stops of itself, probably owing to the diminution of blood pressure by the sudden loss of blood leading to blocking of the bleeding vessel by clot. The bleeding in many cases recurs, in days or weeks or months, or even only after years. I have notes of a case which I shall read to you presently, in which a man had a hæmorrhage 15 years ago, another 10 years after that, and another five years later still. In another case, a gentleman upon whom I recently operated had a hæmorrhage last May, and another very severe one in August.

4. The fourth result is *cicatricial contraction*. Ulcers, especially those in the pyloric region, tend to cause contraction as they heal and cicatrise, and the result is pyloric obstruction which is often very marked so that the pylorus may be almost occluded. A very considerable proportion of cases of gastric ulcer which are recognised clinically and at operation are found to have caused a good deal of obstruction at the pylorus. Cicatrization may also occur owing to the contraction of an ulcer in other parts of the stomach, causing what is known as "hour-glass" stomach.

5. Fifthly, simple ulcer of the stomach may become *malignant*. This is a difficult question; it is very hard to say how often a gastric ulcer becomes malignant. It is difficult in many cases to say for certain when you see malignant disease of the stomach, either on the operating table or in the post-mortem room, whether or not it is the result of a simple ulcer, though some undoubtedly are. Moreover, opinions on the subject vary very much indeed. At the same time there is no doubt that a certain proportion of the patients operated upon for an apparently simple ulcer of the stomach die of cancer of the stomach. I cannot give you any idea what the proportion is; I have known of only very few cases. The only statement of any definite proportion I have come across is that of Eiselsburg, who says that 10 per cent. of his cases of gastric ulcer which were operated upon died of cancer of the stomach. He is a well-known authority on gastric disease. Moynihan, again, has stated that more than 72 per cent. of gastric cancers are undoubtedly preceded by simple ulcer. That is a very definite statement. I do not know how it was arrived at, but at any rate, it shows how strong is the opinion on the subject held by a well-known surgeon and very good observer. So we may say that gastric ulcer certainly may become cancerous, but the degree of risk is doubtful. A curious fact worth noting in this connection is that although gastric ulcers do become cancerous, yet in regard to duodenal ulcers the position is exactly the reverse in spite of the fact that ulcer of the duodenum is commoner than ulcer of the stomach. Sir John Bland Sutton, in a recent paper, went so far as to say that cancerous change in a duodenal ulcer is unknown.

Let us now consider the clinical side of the subject.

In dealing with the symptoms of gastric ulcer, I think that it is best to consider the cases in three groups. In the *first group* symptoms are absent. It is important to remember this. It is an undoubted fact that many people who have gastric ulcers have no symptoms. I have operated upon a number of patients for perforation, and have often questioned them and found they had had no previous symptoms and had no idea whatever that anything was the matter with them. Moreover, gastric ulcers are found unexpectedly *post-mortem*. That is not so conclusive perhaps. The surgeon or physician attending the patient for something else, such as pneumonia, would not be inclined to lay stress on the patient's indigestion.

With regard to *group 2*, I think they are best described as *atypical*. A certain number of patients are found to have unsuspected gastric ulcers, either at *post-mortem* examination or on the operating table. Sometimes these patients have symptoms which resemble those of other well-known conditions. For instance, in a considerable number of cases, operation for supposed gall stones reveals the presence of gastric ulcer: it may be very difficult to distinguish gall stones from gastric ulcer. Other cases of ulcer are diagnosed as adhesions and chronic appendicitis. Some are indefinite to such a degree that an operation is undertaken

purely as an exploratory measure, and a gastric ulcer found.

In *group 3* the symptoms may be described as *typical*. The typical symptoms of gastric ulcer are as follows :—

First, *pain*. The amount and degree of pain are variable, partly because no two people interpret the same amount of pain in the same words. Still, you may say, broadly, that pain is one of the definite symptoms of typical cases of gastric ulcer. As a rule the pain is intermittent. I had better explain that a little further. Take an instance: a patient will tell you that he has had symptoms of indigestion —pain after food, in attacks, for five or six or ten years. He will have a bout of pain which will last, perhaps, a month. Possibly as a result of exercising more care in his diet, and of rest, or a regular course of treatment, he gets better, and may remain entirely free for some considerable time, after which the symptoms will come on again. If these patients suffered from continuous pain, never being free of it, they would probably be seen much earlier. There is no doubt that the reason one sees so many cases of gastric ulcer in people who have had the symptoms for years is, that while they are making up their minds about going to a hospital or consulting their doctor they begin to get better of that attack, and they put off any steps towards being dealt with until they have another bout. As regards the site of the pain, it is situated, almost always, in the epigastric region, sometimes a little more to the right sometimes a little to the left, sometimes going through to the back. But it is always, more or less epigastric.

The next point is, that the pain is related to food. Patients who have gastric ulcer are always more comfortable when the stomach is empty, and their best time is in the morning, before they have had anything to eat. They will, mostly, tell you that the pain comes on after food. The period after the ingestion of food which elapses before the pain comes on varies very greatly, and to some extent—one cannot lay down a hard-and-fast rule—according to the position of the ulcer: the nearer the ulcer is to the pylorus, the later after food the the pain is likely to come on.

The second symptom is *vomiting*. Many patients with gastric ulcer are sick, generally in bouts, as with the pain. Mostly, they say the sickness makes them feel very much better. Of course, there is more liability to sickness if the patient has definite obstruction, from cicatrisation of the pylorus with consequent dilatation of the stomach; but vomiting is common quite apart from pyloric obstruction and may possibly be due to irritability of the stomach just as ulceration of the bladder causes irritability and frequency of micturition.

On the other hand, some patients are not sick at all, even though obstruction is present. I last week operated upon a lady who had never been sick. She had had symptoms for four years, and a large proportion of her bismuth meal was present in the stomach eight hours after she took it. That indication of obstruction was confirmed at the operation, because the pylorus was much obstructed by a cicatrising ulcer. Sickness, therefore, is not a constant symptom.

We next come to *local tenderness*. That is fairly constant. On examining the abdomens of patients with gastric ulcer, I think it is true that in a very large proportion there is found to be tenderness somewhere round about the

epigastric region. But the degree of tenderness, both in the same patient at different times and comparing different patients, varies a good deal.

The results of X-ray examination I cannot go fully into. There are, however, three principal points to remember. The first is, that in a considerable proportion the bismuth meal is found to be hurried out of the stomach, showing that the organ is in a hypertonic or irritable condition. The second is that in a large group of cases the reverse is the case, for in cases with obstruction more or less of the bismuth meal will remain in the stomach five hours or more after the meal was given. Thirdly, an irregularity in the normal outline of the stomach may occasionally be made out and may indicate the actual site of an ulcer. There are other points in X-ray examinations of such cases, which cannot be gone into at this time.

These, then, are the chief symptoms and signs of gastric ulcer apart from the symptoms produced by complications. Those time will not allow me to deal with separately.

Now let us pass on to the question of treatment. In the first place, as I have already said, a large proportion of patients who have symptoms of gastric ulcer get well as the result of medical treatment.

What, then, are the indications for surgical treatment? The cases of gastric ulcer in which surgical interference is needed fall into two classes which are as follows :—

1. Those cases of uncomplicated gastric ulcer in which a fair trial of medical treatment has been made and has failed to relieve the symptoms.

2. Cases of gastric ulcer complicated by:—
   a. Perforation.
   b. Hæmorrhage.
   c. Pyloric obstruction or hour-glass contraction.

The following is a good example of the type of case, coming under the head of the first indication: *failure of medical treatment.* The patient was a lady, aged 35, whom I operated upon in July, 1911. I have chosen this case because the operation was done some time ago, and I have been able to keep in touch with the patient and her doctor, so I know what the subsequent course of events has been. She had for many years suffered much from attacks of very bad pain, which had become more and more frequent, in spite of care in regard to diet. These attacks of pain had been associated from time to time with vomiting. When I saw her, her diet had been, for twelve months, limited to milk; and during the last few months, in spite of the fact that she was taking nothing but milk, she was getting more and more pain, so that her life had become intolerable. I operated in July, 1911, and I found an ulcer on the anterior wall of the stomach, with much thickening round it, and about one inch away from the pylorus. I did a posterior gastro-jejunostomy, and, to put it shortly, she has not had any trouble since. I saw her quite recently—seven years after the operation—and she told me she could eat and drink anything, and had not had any signs of indigestion nor any of her old pain.

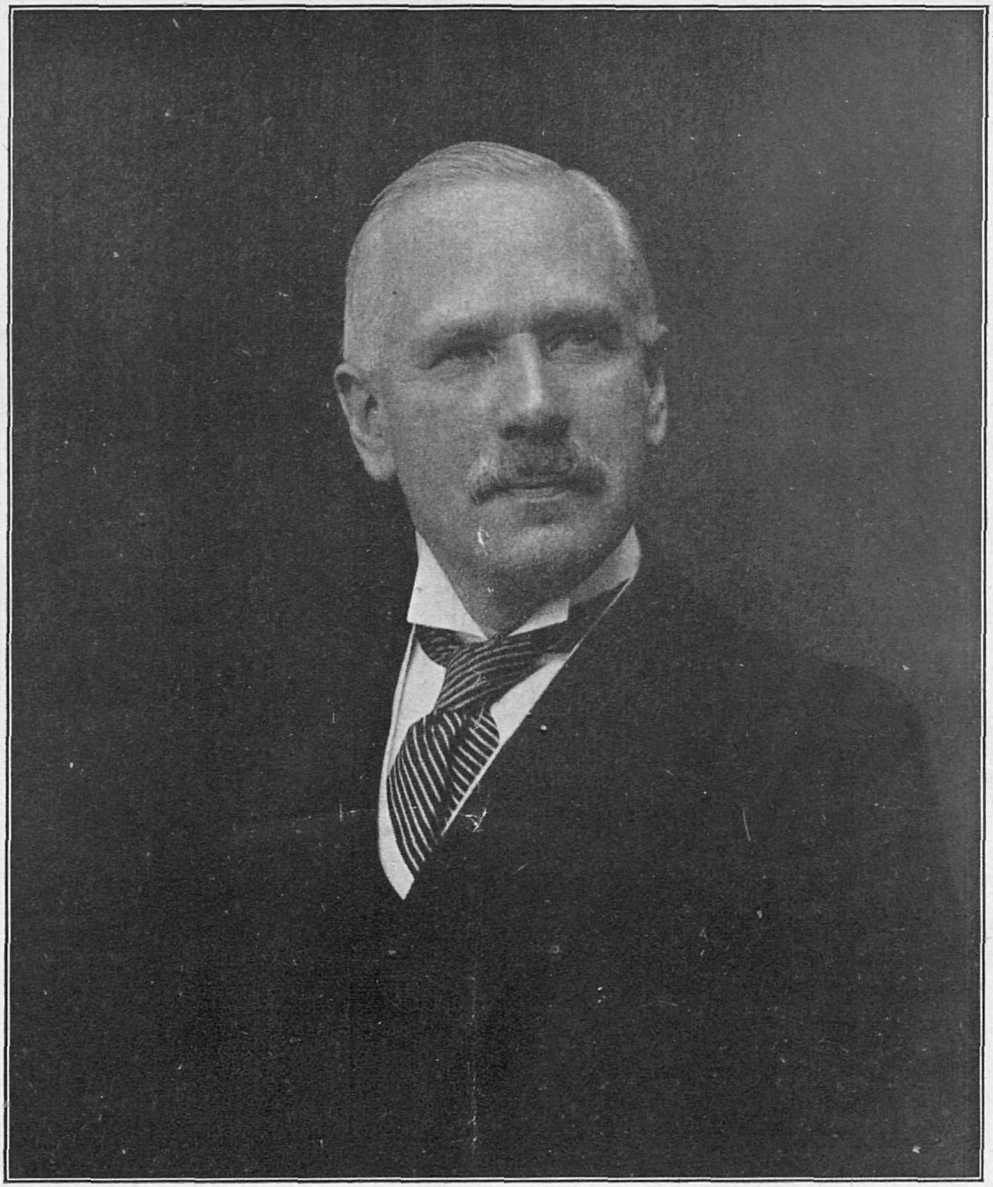
You will have noted that the operation I performed in this case was gastro-jejunostomy, which I did in order to short circuit the ulcer. When gastric ulcers were first operated upon —which is not so very many years ago—the operation which was always done was gastro-jejunostomy. The main reason for this was that it, in the first place, relieved obstruction, and as, in a very considerable proportion of cases of gastric ulcer, obstruction was present, the result in those cases was extremely satisfactory. In other cases, in which there was no obstruction, it was thought the patient would

be benefitted by the fact that as the contents of the duodenum flowed into the stomach, the gastric contents would be kept more or less alkaline and the ulcer would in consequence heal. Some surgeons still hold that that is a very important factor. As time passed it became clear, however, that gastro-jejunostomy alone did not always produce the results which were hoped for from it. For this reason and also on account of the danger of subsequent cancer, other methods of treatment have, of more recent years, been advocated.

With regard to the results of gastro-jejunostomy, it is necessary to remember that there is a mortality which is variously put by different writers between 2 per cent. and 10 per cent. In the practice of surgeons who do many gatsric operations the mortality will only reach the lower figure, while in the hands of less experienced operators it will be higher. Sometimes the patient dies because the hæmorrhage for which the operation was done continues. Others, owing to their vitality being much diminished by perhaps years of semi-starvation, easily get bronchitis, pneumonia, etc., and a certain number succumb from these complications. Probably the mortality from simple gastro-jejunostomy is being diminished as surgeons become more skilled, and everything connected with surgery gets more refined. As regards final results it is probable that gastro-jejunostomy alone will cure about 60 per cent. of the cases of gastric ulcer which require operation, but the higher the proportion of cases with obstruction the better will be the final results.

With regard to other methods of treatment, sometimes the ulcer is excised, either with the knife or by the cautery, so securing a bloodless removal, or a pylorectomy or partial gastrectomy may be performed, and, according to the position of the ulcer a gastro-jejunostomy may or may not be done afterwards. All those methods have been carried out with more or less satisfactory results. But the one fact which comes out quite clearly is this: that as soon as you begin to do anything, other than gastro-jejunostomy, on these patients—who are often already half-starved, and therefore not in a condition to stand operation well—the mortality goes up tremendously. I have taken some figures for your information from one of the recent books on Diseases of the Stomach—Bassler's book. He has collected together the results of operation for gastric ulcer by 14 different surgeons. There were 1650 operations and 95 deaths, that is, a mortality of 16·3 per cent., the operations including gastro-jejunostomies, excisions, pylorectomies, resections, and so on. The mortality associated with any other operation than gastro-jejunostomy is, therefore, very considerable. The only thing which may justify it is this—and it is a question which one must ask—is it right to submit your patient to this much increased risk and remove the ulcer in order to save him from the unknown risk of the subsequent development of cancer in the ulcer if not removed? Personally, I think not except in regard to a very small number of the cases, but many surgeons think otherwise. If I do not think a case will be cured by gastro-jejunostomy, I consider that usually the right treatment is to perform jejunostomy and feed the patient temporarily directly into the jejunum.

Some of the reasons why I think jejunostomy is the better procedure are these. We know that a considerable proportion of cases of gastric ulcer heal as the result of the incomplete rest to the stomach which is obtained by medical treatment; one may, therefore, quite fairly argue that as a result of the absolutely complete rest to that organ which is given by jejunostomy, the proportion which will heal will be very much greater. Further, the operation



Sir ARBUTHNOT LANE, Bart.

of jejunostomy is a slight one; I do not think it is attended with nearly so much risk as is even gastro-jejunostomy, and, of course, far less risk than excision or any of the more extensive operations on the stomach. Again, if it is properly performed it does not cause much inconvenience to the patient. Moreover, such inconvenience as there may be is a temporary matter, because after five or six weeks the opening is allowed to close.

The following case illustrates some of these points:—W. S., a male aged 54, was admitted on December 6th, 1917, with the following history. Four months ago he began to have pain in the epigastric region immediately after taking food. This soon became severe, but was relieved for a time by careful dieting. The relief, however, was of short duration, and he had to give up one article of diet after another, so that during the fortnight immediately preceding admission he had taken only diluted milk in small quantities at a time, and even this was now followed by severe pain. He had lost much weight, about 2 stones, and on admission he was thin, but not emaciated. He had not vomited, nor even felt sick. Physical examination did not reveal much, but there was definite tenderness in the epigastric region in the mid-line and a little to the left of it. The X-ray investigation after a bismuth meal revealed hypertonicity of the stomach, but no other abnormality. Clearly this was an instance of failure of medical treatment, because, in spite of being given nothing but diluted milk, he was still having severe pain. On December 13th I opened his abdomen and found a large ulcer, situated on the back of the fundus of the stomach. It felt to be about the size of a half-crown, and was firmly attached posteriorly. Now this patient was very weak; he had been starved for a long time, and clearly it would have been a very serious proposition to have proceeded to excise the ulcer. Therefore, I performed jejunostomy. We began to feed him through the jejunostomy opening the next day with small quantities of peptonised milk at first, gradually increasing until he could take, without discomfort, 12 oz. of food at a time. In his food he had three eggs during 24 hours. At Dr. Fawcett's suggestion he was given some lime-water to drink, and also bicarbonate of soda after his feeds, so as to neutralise the gastric juice which was probably secreted at the time of feeding into the jejunum. He was fed entirely by the jejunostomy for five weeks, and then was given a little food by the mouth and less by the jejunum, until, at the end of six and a half weeks the jejunum was allowed to close, and he was fed entirely by the mouth. The weight-chart during this time was very interesting. His weight remained fairly constant all the time he was being fed by the jejunum, between 8 st. 1 lb. and 8 st. 2 lbs. But within a week of commencing food by the mouth his weight went up 4 lbs, in the second week 5 lbs., and in the third week 6 lbs. So it is clear that although this operation may rest the stomach, the nutrition of the patient is not altogether satisfactory although plenty of food was given and apparently absorbed.

He was discharged in good health and free from pain or tenderness on the 22nd February, 1918, his weight being 9 st. 3 lbs., and he told me that from the time of the operation he had never experienced his old pain. By lucky chance he saw me yesterday in the ward. He looks the picture of health, says he is in perfect health, and, in his clothes, he weighs $11\frac{1}{2}$ stone, so that, allowing half a stone for the weight of his clothes, he had increased since the operation from 8 st. 2 lbs. to 11 st.

The following case comes under the third indication for operation—*bleeding*. For some

months the patient, a gentleman of the age of 42, had suffered from pain one or two hours after food, but had had no special treatment. Suddenly, on May 3rd, 1918, he had a serious hæmorrhage and fainted. He brought up a quantity of blood and subsequently had malæna, and he was laid up in consequence for some considerable time. He then apparently recovered except for some indigestion. But on August the 21st he had a second severe hæmorrhage. He subsequently came under my care at the beginning of October. He was still very blanched, so his fæces were tested and occult blood found on two occasions. There was thus little doubt that his ulcer was still bleeding. I opened his abdomen and found an ulcer which was causing some contraction of the pylorus. It was much indurated and was situated immediately to the left of the pylorus.

I did a posterior gastro-jejunostomy, from which he rapidly recovered, and I received a letter from his doctor this morning saying that he is looking and feeling perfectly well, and is a much better colour.

This case very well illustrates the accepted practice in regard to the treatment of a gastric ulcer which bleeds, except that after such a severe hæmorrhage as this patient had in May it seems to me that it was not necessary to wait for a second hæmorrhage before advising operation, although it is true that an ulcer may heal after one attack of hæmorrhage and give no further trouble.

Some years ago it was the practice of some surgeons to operate on these patients while bleeding was going on with the object of stoping the hæmorrhage, but as nearly all the patients died, this is now seldom done. On the other hand, if, as in the above case, the patient is put to bed, kept perfectly quiet, given some morphia, and perhaps a little iced water to drink, he will almost certainly recover from the hæmorrhage. Now, if such a patient has recovered from one or more severe hæmorrhages or has had a large number of small hæmorrhages, or is pale because of hæmorrhage, which shows itself in the form of occult blood on examination of the fæces, there is a definite indication for operative interference.

4. *Contraction.*—If there is evidence that a gastric ulcer is causing contraction, you have the clearest indication for surgical interference. If there are symptoms of stomach dilatation, a succussion splash some hours after a meal, possibly visible peristalsis, and examination by X-rays after a bismuth meal shows that a considerable proportion is left in the stomach after an interval of six hours, that is evidence of contraction of the pylorus, which is almost certain to be progressive, and which no amount of medical treatment can alter. Moreover, this is the condition in which, as one would expect, gastro-jejunostomy is attended with by far the best results, in fact, it is nearly always perfectly successful, and the rapidity with which recovery takes place is often most striking.

Here are notes of two cases of the kind:—

The first patient was a man, æt. 49, sent to me by Dr. Monro of Catford, who had had indigestion, more or less, for many years. During bad attacks he also frequently vomited. Pain was brought on by food, and usually came on an hour to an hour and a half afterwards. In February, 1918, he brought up some blood and was in bed for a fortnight. On examination it was found that his stomach was considerably increased in size, and there was a very marked splash, but no peristalsis was visible. He was able to take fluids only, but, in spite of that, every now and then he vomited considerable quantities. I had no doubt that

he had a cicatrising ulcer, which was causing pyloric obstruction, so I operated and found a large ulcer of the lesser curvature, close to the pylorus, and causing much obstruction, for which I did a posterior gastro-jejunostomy. I have heard recently that he has done perfectly well and is in better health than for many years.

The other case was sent to me by Dr. Wetherell, of Ipswich, last summer. He was only 33 years of age and had been invalided out of the army on account of his indigestion. This he had had for many years, but while in France he had become much worse than before, and when I saw him he was having a good deal of pain in the epigastric region, which was usually worst during the night, so that his sleep was much disturbed.

Vomiting was not frequent at all, occurring only once every two or three weeks when he brought up a large quantity of fluid, with much temporary relief. He looked thin and ill and examination pointed to a dilated stomach. This the X-ray examination confirmed, a considerable proportion of the bismuth meal remaining in the stomach after nine hours.

At the operation the pylorus was found to be much contracted by a cicatrising ulcer, and a posterior gastro-jejunostomy was performed. In a letter written two months after the operation he says he has had no further pain, is perfectly well, and had gained half a stone in weight in the last fortnight, so that he has good reason for his satisfaction with the result of the operation.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Hospital Physiological Society.

A MEETING of the above Society took place on January 31st, at which Dr. Laidlaw again occupied the chair.

On the conclusion of the Society's private business Mr. Graydon Hume read a paper on "Shock," briefly reviewing some of the latest theories and comparing these with some of the older ones. Shock was defined as an indefinite term to express depression of the vital centres, and it could not be described as due to any single cause, but rather as a combination of many, such as hæmorrhage, exposure, nocioceptive impressions, trauma, etc.

Crile's theory of vasomotor collapse, in which the arterioles are said to be released, is based upon the diminution of reflexes, chromatolysis of nerve cells, and disappearance of Nissl granules in the cuneate and gracile nuclii and in Purkinje cells of cerebellum, which lesions are said to follow the reception of nocioceptive impressions.

Yandall Henderson, on the other hand, attributes the state of shock to be entirely due to the small amount of CO_2 which reaches the respiratory centres in that state. This theory is disproved by Crile's cross circulation experiments.

Mummery states that the arterioles are often contracted in shock, and that the blood pressure is not always low.

Cannon has propounded another theory—the "the exæmia" theory—in which histamine is said to be set free into the circulation. This drug alters the permeability of the capillaries and consequently the aqueous contents of the blood are exuded. Thus, the specific gravity and viscosity of the blood rises; but on transfusion of saline does not materially affect the

blood count. The paper concluded with a summary of treatments which have been tried.

The meeting was greatly indebted to the Chairman, who has recently done a great amount of research on this subject, and who gave a brief survey of the results he had achieved. All the symptoms, he said, could be attributed to low blood pressure. The question was, where did the blood go to? It was not in the arteries, nor in the veins, and in those cases which were without hæmorrhage, it was not lost from the body. He was convinced that this blood was in the capillaries, and, when one understood the vast area of the capillaries and amount which they might hold in terms of the total amount of blood present in the body, there was no great difficulty in attributing the low blood pressure present in shock to engorgement of the capillaries.

It was an extremely difficult task to produce artificial shock in an animal by any of the old-established methods, such as manipulation of the intestines for hours, really proved very little. Trauma played a large part, and the work of research was greatly complicated by the variety of causes.

The action of the drug histamine—that of enlarging the capillaries—was extremely useful in that it produced a condition exactly similar to shock, and this went to show that toxin released into the circulation was really the cause of the condition, in that it was mainly responsible for it.

The discussion following on the paper and the Chairman's speech centred round the mobility of capillaries and the pro's and con's of their great part, as propounded by the Chairman, taken in the condition under discussion.

The meeting closed with a hearty vote of thanks to Dr. Laidlaw for occupying the chair.

Guy's Hospital.

IN accordance with annual custom, the House Committee publishes for the information of the Medical, Surgical and Nursing Staff the following tables showing the total number of patients sent during the past year to Convalescent Homes and Sanatoria :—

WARDS.	Number of Patients. 1917	1918
Astley Cooper	7	8
Cornelius	11	11
Lazarus	64	37
Job	39	22
Naaman	27	14
Luke	35	26
Evelyn	17	16
Patience and Samaritan	25	9
Charity...	49	61
Dorcas	28	45
Lydia	53	31
Martha	28	22
Eye Wards	28	12
Addison	39	31
Mary	29	15
Esther	25	30
Queen Victoria	23	14
Clinical	35	23
Isolation	1	—
Out-Patients' Department ...	90	120
	653	547

The subjoined list gives the distribution of the patients amongst the various Homes :—

Ascot Priory (Women and Children)			91
Burns Home (Children)			69
Merchant Taylors' Home, Bognor (Men) ...			44
Metropolitan Convalescent Institution :—			
Bexhill (Women) ...	53	83	
„ Little Common (Men)	68	46	
Walton-on-Thames (Men and Women)	—	30	
		—	159
Rustington Convalescent Home			15
Schiff Home of Recovery...			40
			418

SANATORIA.
(Beds allocated free of charge to the Hospital by the King's Fund.)

Devon and Cornwall Sanatorium	12
Kelling Sanatorium, Holt Norfolk	6
Holt Sanatorium (Children)	5
	441
In addition to the above, 106 patients have been sent to various places for convalescent treatment, principally in co-operation with the Charity Organization Society and the Invalid Children's Aid Association	106
	547

List of amounts received from patients in the various Wards, and sums found in Ward Collecting Boxes, etc., for the year ending Dec. 31st, 1918. The amounts received in the previous year are inserted for the purpose of comparison.

	Box Collections. 1918 £ s. d.	Special Donations. 1918 £ s. d.	Totals for 1917 £ s. d.
Front Gate Box ...	5 18 5	—	5 13 10
Porter's Lodge ...	9 16 0	—	10 11 0
Out-Patient Depart.	35 1 1	9 17 0	39 16 5
Surgery	19 3 3	1 1 0	12 12 6
Dental Department	2 10 3	1 1 0	5 0 4
Light „	12 16 3	13 9 0	58 7 7
Massage „	73 2 2	4 10 0	79 5 2
Electrical „	10 11 2	5 2 0	10 13 6
WARDS.			
Addison	3 16 9	26 15 6	36 19 7
Astley Cooper ...	3 5 8	43 18 6	26 17 3
Bright	3 10 11	12 12 0	20 10 11
Charity	5 9 6	58 2 0	13 8 11
Clinical	3 9 10	14 0 0	15 3 0
Cornelius	1 0 7	15 1 0	42 2 11
Dorcas	9 0 5	138 11 0	111 11 7
Esther	2 7 9	52 0 0	33 9 11
Evelyn	3 1 6	37 3 6	18 1 6
Eye	8 16 2	22 12 0	19 16 1
Job	6 12 10	37 4 0	27 9 6
Lazarus	1 19 6	41 2 6	60 15 2
Luke	2 8 6	27 10 0	32 19 4
Lydia	7 5 2	51 13 6	69 6 0
Martha	5 8 9	152 16 0	48 2 4
Mary	1 6 2	43 11 0	25 12 0
Naaman	7 12 0	31 9 0	37 18 5
Patience	2 8 7	6 5 0	1 4 7
Queen	14 4 4	86 15 0	124 17 9
Officers' Section ...	1 18 1	37 0 0	64 19 2
	£264 1 11	£971 1 6	£1053 6 3

TOTALS.	1918 £ s. d.	1917 £ s. d.
Box Collections ...	264 1 11	236 14 9
Special Donations ...	971 1 6	816 11 6
	£1,235 3 5	£1,053 6 3

In addition to the above the following sums have been received from patients in respect of treatments during 1918.—

	£ s. d.
Light Department ...	51 7 6
Massage „ ...	104 13 9
Electrical „ ...	13 13 0

Letters from Old Guy's Men on Active Service.

The following is an extract from a letter from Capt. M. J. T. WALLIS, R.A.M.C.

I engaged a ruffian to show me some of the sights in this city of abomination. We went part of the way on a tram, and then feeling proud we procured a garry. The last part of the journey to the Pyramids was done by the ruffian on a donkey, and by yours truly on a camel. I look an awfully reckless fellow on a camel.

Now I had contracted with the aforementioned ruffian to deal direct in the payment of lesser ruffians who rom time to time presented themselves as guides of some particular thing or other. It was in fact his own suggestion, and one made in the precincts of the biggest pyramid into which I went. I was subsequently conducted by two of the lesser rogues into the tomb of the dear old gentleman who built it; also into that of his wife. When we got into this delectable cavern, about 300 feet above the ground, after climbing through a tunnel on all fours for about quarter mile, the lesser rogues gave tongue and unburdened their souls about my own ruffian who was waiting outside. They said crudely that they wanted their tip from my own lily white hand, insinuated that otherwise my own ruffian would extract commission out of the transaction, said that they had overheard his advising me to pay them through him, and that they would like payment "statim," and finally hinted at my finding it extremely difficult to get out of the salubrious hole if I did not comply with their wishes on the subject. One said "We have satisfied you, and now you are going to satisfy us." There was evidently going to be a perfect glut of satisfaction all round.

So I said, "My friend, I believe you're an optimist." But he wot not the meaning of the word. So with that indomitable courage that has made we English what we are, I lifted up my voice and spake. Told them that I would indeed remunerate them with my own dainty fingers, but that it would be done in the presence of, and after consultation with my own pet ruffian. That they should in no wise be enriched until we reached terra firma; that I would not pay nine piastres for two inches of flaming magnesium wire used to illuminate the tomb of the most illustrious Pharaoh, who ever gargled in the Nile, and finally intimated that I'd no doubt that the marriage lines of their parents had been mislaid.

After this there was considerable hab yab in the vernacular, which did not terminats until we reached the light of day. But I maintained a Napoleonic silence.

Apart from these rascals and two more in the temple of the Sphynx, and a fifth whom I was told one had to pay because he was so very ancient, the owner of the donkey and the owner of my flea-bitten camel and my own villain, I did not have to disgorge more pelf at this particular spot, though there were plenty of opportunities of doing so. Ancient Roman coins were thrust towards me by diminutive and grimy paws. I said that the only coins I collected were the current ones of the realm.

Then a man with a face like a vacuum cleaner became most persistent in his desire to tell me my fortune by looking at my palm. So I told him to make a noise like a brook and trickle away.

Then as a sort of climax of enjoyment my guide suggested that for a suitable remuneration (to be named

later) an Arab would climb up to the top of the big pyramid and down again in exactly 8 minutes. His suggestion that I could not do it myself under thirty-five minutes was negatived without a division or an experiment. I explained to him that though my best time for the performance was 7 min. 54⅘ sec., there was little doubt that it had been done in the States in 7 min. 51⅕ sec., but that it was possible that the wind had somewhat assisted the athlete in the American record. In any case, any time outside 7.58 left me quite cold.

Went to the Bazaar and the Mosque in the afternoon. When I got to the end of a perfect day, I discovered that the knaveries of all the lesser rogues paled into insignificance by the side of the glaring attempts at impudent extortion which my own pet ruffian made upon me.

Shepheard's Hotel,
Cairo.

Guy's Hospital Missionary Society.

RECEIPTS AND PAYMENTS FOR THE YEAR ENDED DECEMBER 31ST, 1918.

Receipts.

	£ s. d.	£ s. d.
To Balance brought forward—		
Cash at Bank	11 15 6	
Petty Cash in hand ...	2 2 0	
		13 17 6
„ Subscriptions and Donations ...		14 14 0
		£28 11 6

Payments.

	£ s. d.	£ s. d.
By Subscriptions to other Funds ...	10 10 0	
„ Printing, Stationery, Magazines, etc.	1 16 8	
„ Postages	0 3 6	
„ Balance carried forward—		12 10 2
Cash at Bank		16 1 4
		£28 11 6

Audited and found correct,
Jan. 8th, 1919. W. J. CURRY.

Change of Address.

Mr. E. C. Hughes, from 37, Queen Anne Street, to 16, Harley Street. Tel.: Mayfair 2029.

Capt. C. Dean, R.A.M.C., att. 1st West Yorkshire Regt., B.E.F. (Army Occupation. Germany).

Lieut. K. Mullen, I.M.S., c/o Capt. A. H. Mullen, Marston Road, Karachi, India.

E. G. Slesinger, Esq., F.R.C.S. (Eng.), late Temp. Surg.-Lieut. R.N., from Millicent Sutherland Ambulance, B.E.F., to 41, Upper Gloucester Place, Regent's Park, N.W. 1. Tel.: Pad. 4832.

P. R. Helyar, from Military Hospital, Sanchurch, to 41, Eversfield Place, St. Leonards-on-Sea.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—To those of us who work in laboratories the recent discussions in "The Times," on the sub(ect of Medical Research, have been of great interest.

On January 11th there was an admirable letter by the Dean of the Charing Cross Medical School, in which he states "The financial aspect is the basis of the whole question." Quite recently, a bequest of £150 a year has been left to Guy's Hospital for the study of little known diseases. One is grateful for this generous gift, for compared with other countries how little is given in England for the cause of scientific research? A stipulation of this bequest is that whosoever receives it should devote half his time to the study of ths subject to which it is allotted.

Does not that show how little the financial aspect of the question of research is understood? How can anyone, unless he has private means—having regard to the present purchasing power of a sovereign—give up half his time for £150 a year? —I am, yours faithfully,

H, M. M. WOODWARD.

Honours.

M.C.

Temp. Capt. D. H. A. Galbraith. For conspicuous gallantry and devotion to duty. He was wounded in the head whilst attending to a wounded officer, and though in great pain continued to carry out his duties for the remainder of the day with zeal and determination.

Mentioned in Despatches.

The names of the following medical officers have been received from the Commander-in-Chief of the Egyptian Expeditionary Force as worthy of mention for their services during the period from March 16th to Sept. 18th, 1918.

A.M.S.

Temp. Capts. H. Cardin, E. G. Goldie.

R.A.M.C.

Major J. Evans; Major A. Thomas; Capt. (Acting Major) G. B. Pritchard; Capt. H. W. Evans.

I.M.S.

Lieut.-Col. (Temp. Col.) W. H. Ogilvie, C.M.G.

Pass List.

Royal Colleges of Physicians of London and Surgeons of England.

FIRST EXAMINATION.

Chemistry.—A. H. Brockbank. G. E. Fisher, M. Mitmans, D. B. Whitlock, C. T. Pomeroy, D. A. Windemar, J. S. Hudson, R. M. L. Still, W. A. Krige, D. G. Robinson, G. M. Mew, J. Freiberger.

Physics.—A. H. Brockbank, G. E. Fisher, M. Mitmans, D. B. Whitlock, D. A. Windemar, J. S. Hudson. J. J. Bechal, W. A. Krige, D. G. Robinson, G. M. Mew, J. Freiberger, E. Clark.

Elementary Biology.—A. H. Brockbank, G. E. Fisher, M. Mitman, C. T. Pomeroy, D. A. Windemar, F. J. Smith, M. Hawke.

SECOND EXAMINATION.

Anatomy and Physiology.—B. Kessel, A. R. Patel, G. W. Elkington, M. Hall, R. J. Hooker, F. W. Widgery *G. B. Kirkland, †A. B. Aldred, *E. Hardy.

*Anatomy only. †Physiology only.

FINAL EXAMINATION.

Medicine.—F. G. S. Bonar, H. M. Brown, G. O. Hume, C. T. Helsham, A. A. Osman, A. E. Sawday.

Surgery.—A. K. K. Dina, G. B. Dowling, T. Fernandez, E. J. Gaffney G. O. Hume, S. T. Wong. F. Young, E. R. Webb.

Midwifery.—W. McB. Allan, C. H. Bubb, G. L. Cutts, W. T. Flooks, St. G. B. D. Gray, C. H. S. Horwitz, G. Packham, W. W. Payne, R. C. B. Ledlie, H. N. Shapiro, W. A. Turner.

Football.

ASSOCIATION.

GUY'S v. ST. BARTHOLOMEW'S.

Played at Winchmore Hill on January 18th. Owing to their original fixture having been scratched, Bart's. arranged this game with us, at two days' notice, and the result was a very enjoyable contest—though a loss for us by 4 goals to 1. The weather was fine, but the heavy rains had made the ground soft in parts. Perhaps this was fortunate for us, because their extra weight was of no avail with the slippery ground and wet ball. Our forwards started well, but soon most of the play took place in our own half, and our goalkeeper was kept continuously busy. A good passing movement by our left wing almost resulted in a goal, and for a time play was more even. But during most of the first half we were kept on the defensive, and they scored 3 goals.

The second half was quite different. From the outset the forwards played with more dash and the halves followed up better. This was quickly rewarded, Harris putting the ball into the net. Play continued even for some time, our goalkeeper clearing two dangerous shots in magnificent style. Before the end they scored again. Thus ended our first match—and though beaten, yet with redoubled keenness for the future.

TEAM.—H. Jones (goal); H. L. Bernstein, E. C. Warner (backs); E. F. Strong, G. P. Lindsay, C. H. C. Toussaint (halves); J. D. S. Thomas, W. A. Caldwell, J. E. Harries, R. M. Lloyd Still, H. N. Schapiro.

GUY'S v. LONDON HOSPITAL.

February 1st, on our ground which was frozen hard and covered with snow. After two trial games the team to represent Guy's in this match had to meet a strong side which, after some months of playing together, had developed a skilful combination. The ball was very light and the Guy's forwards were quite unable to control it. Consequently our defence had a strenuous time right from the start. In the first half they scored twice, while the Guy's attack lacked sting and failed to score.

After the change over the London forwards started off at a great pace and added three more goals in quick succession. The effect of this was to pull our team together, and for a time play was more even, although only once did our attack look dangerous, and then we were unlucky in not scoring from a scrimmage right in their goal mouth. Their forwards soon pressed again and our hard-worked defence could not prevent them again scoring three more goals. Thus we lost by 8 goals to nil. Hewlitt played well at back. Gregor and Harris worked hard to the end. But the side is not individually a strong one, and it will win its successes only by learning to combine, and by sheer sticking to it from start to finish.

TEAM.—L. W. Cann, P. Sedgwick, G. P. Lindsay, E. R. Webb, J. D. S. Thomas (forwards); J. B. Gregor, R. J. Cann, H. A. H. Harris (halves); E. F. Hewlitt, J. Bechal (backs); W. G. Hore (goal).

RUGBY.

GUY'S v. No. 15 O.C.B.

Played at Gidea Park on January 18th. Guy's gained an easy victory, being superior in every department of the game, especially forward. Eight tries were scored but owing to the heavy state of the ground only one was converted. The Cadets were only once really dangerous, and if Guy's had really exerted themselves a much bigger score would have resulted.

Within two minutes of the start Doherty gathered and raced over with a try. A few minutes later the forwards went over in a body and scored another unconverted try. About ten minutes before the interval Shelswell intercepted a pass and scored behind the posts: again the kick failed. Another bout of passing sent Krige in, and half-time came with Guy's twelve points to the good.

The Cadets started in rather better fashion after the interval, but the improvement did not last and Reitz was soon over again. Further tries were added by Crisp, Reitz and Woodroffe, the last one being converted by Marais. Guy's were thus left winners by a goal and seven tries to nil. Although such an easy win, the team will have to make decided improvement before they meet Barts.

The threes, with the exception of Krige, did not seem to have any life in them, and a little more determination in their running would have led to several more tries. Among the forwards, Reitz, Doherty and Shelswell were always conspicuous.

TEAM.—A. Shaw (back); B. C. Woodroff, E. J. Crisp, P. Kriige and P. Morrison (three-quarters); W. H. Cellier and F. Bekker (halves); F. W. Reitz, W. D. Doherty, A. H. Shelswell, L. K. Watson, C. Marais, G. R. Aspinwall, B. L. Laver and J. A. Curry (forwards).

GUY'S v. ST. BART'S.

The close game at Honor Oak Park earlier in the season naturally aroused considerable enthusiam over the second meeting which took place at Queen's Club on January 25th.

A thaw following a sharp frost had left the ground in a very greasy and muddy condition, and the consequent state of the ball made accurate handling almost an impossibility; the keeness of the defence on both sides also tended to prevent much open play; no man ever held the ball for long, and as a result there was very little scoring.

The game was very evenly contested throughout, Bart's having the greater share of the play in the first half, but towards the end of the second half the Guy's forwards found their real form and from then on had matters more or less their own way. The Guy's pack were slightly heavier than their opponents, and, lasting better, won for them the game.

Bart's started off at a great pace and at once carried the ball into the Guy's "25." Following some hard scrummaging, Guy's forced them back and were awarded a penalty, but Crooks' attempt at goal failed. Again the Bart's forwards, led by Krige, rushed down the field only to be checked by the Guy's defence, which was very sound; Watson had been taken out of the scrum to help the backs, leaving Guy's with seven forwards.

The Guy's outsides now got going for the first time and Woodroffe was nearly over when he was brought down. Another penalty was awarded at this stage: Reitz took a short punt and went hard for the line, but he was held up, and once more Bart's forced their way into the Guy's half. Following a high punt, Llewellyn caught the ball which had bounced away from the Guy's full back, and scored in the corner, Nielle failing to convert.

Bart's now made strenuous efforts to cross again, but the Guy's forwards were beginning to settle down and half-time came without any further score.

On resuming, Guy's at once began to press and within a few minutes a fine forward rush led to Aspinwall scoring far out. Crook converted from a difficult position with a grand kick and gave Guy's the lead.

Play was now very fast, and Guy's again got near scoring but the ball was kicked dead. The subsequent attempts by the Bart's backs to indulge in bouts of passing were spoilt by the defence, and Shelswell, securing the ball, found touch in the Bart's "25." From a scrum the ball came out to Bekker who passed smartly to Cellier; going straight for the line, he transferred to Krige who dashed over with a try. Crook was unsuccessful with the kick.

From now until the end, Guy's were pressing strongly, but no further score resulted, and they were left winners of a fine clean game by eight points to three. For the greater part of the game there was little to choose between the two sides, and at one time it looked as though Guy's would just snatch a victory, thanks to Crook's fine kick, but ten minutes before time the Guy's forwards rose to the occasion and for the rest of the game the issue was never really in doubt.

In a game such as this, it is very hard to single out any one for special mention. The forwards, led by Doherty, did not seem quite happy at the start, but after the Bart's. score they pulled themselves together and showed their very best form. Among the outsides, Reitz and Krige in the centre, played a fine game, both in attack and defence. There was only one unfortunate incident, Doherty sustaining an injury to his hand, which will probably keep him off the field for some weeks. There was a good attendance, and the proceeds were given to St. Dunstan's Hostel for the Blind.

TEAM.—A. K. Day-Lewis (back); H. B. Jones, F. W. Reitz, P. Krige and B. C. Woodroffe (three-quarters); W. H. Cellier and F. Bekker (halves); W. D. Doherty, A. H. Shelswell, F. W. Crook, C. Marais, L. K. Watson, B. L. Laver, G. R. Aspinwall and P. Morrison (forwards). Referee:—Mr. A. J. Trollope.

Births.

EDRIDGE.—On Jan. 20th, the wife (née Keith Murray) of Ray Edridge, of Lynvall, St. Mark's Place, Bath. of a son (Hilary Patrick).

MAXTED.—On Dec. 28th, 1918, at a Nursing Home in Macclesfield, to Capt. G. Maxted, R.A.M.C., and Mrs. Maxted, of 14, Thorpe Mansions, Norwich—a son.

Marriages.

CONES.—TYLER-COVE.—On 25th September, 1918, at the Church of the Holy Name, Bombay, Capt. H. M. Cones, Indian Police (I.A.R., attd. 17th Cavalry), son of J. A. Cones, Executive Engineer (Retired), to Violet Ruth, elder daughter of the late W. J. Tyler-Cove, of Tunbridge Wells, Kent.

WINSTON—GOLDING.—On Jan. 30th, at Linthorpe, Parish Church, Middlesbrough, by the Rev. J. W. Dales (Vicar), J. H. E. Winston, Lieut. 5th Yorkshire Regiment, to Winifred, only daughter of Mrs. Golding, of Middlesbrough, Yorks.

G. B. D.
G. P. L.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 799.] FEBRUARY 22, 1919. [SIXPENCE.

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Passim.

FROM time to time, occurring almost in waves, complaints have been levelled against the Residential College and the conditions of living which are borne by long-suffering residents. Perhaps the most virulent wave occurred about ten years ago, when it was playfully said that no one in the College could ever get into hot water. The outcome of that was the prompt installation of electric light. One theory seems common to all such complaints, and that is that instead of being voiced in the proper place, namely, the general meeting of the Students' Club, they are flung at the feet of the Editor, presumably in the hope that the GAZETTE possesses some superhuman influence over the authorities.

Modesty would forbid us to measure its influence, but, be that as it may, we would bring forward very prominently, not so much a complaint—which is one that is very apparent—but a suggested solution of a widely acknowledged difficulty.

In short, owing to the large number of junior students now in residence, it is often impossible for those holding ward appointments to take rooms in the College. When this definitely militates against their getting the full benefit of their clinical and casualty experience, as in the case of a full surgeon's dresser who for the first month of his appointment was unable to get rooms, it is surely time something was done. Nothing is to be gained by discussing the probable reasons why so many of the College rooms are occupied at the present time by junior men, but certain it is senior men have several times complained of the utmost difficulty, often impossibility, of getting rooms in the College. There is accommodation for about sixty, including House Officers, Externs, etc., and it would seem advisable that the whole of this should be available for men holding ward appointments.

Is it not a practical suggestion that an establishment on the lines of the College should be built away from the present site, say close to the Athletic Ground at Honor Oak Park, or even in some more countrified spot?

The advantages of such an establishment are obvious. The present College is not in a healthy atmosphere. There appears to be no reason why men not holding ward appointments should have to live in the Borough. A College at Honor Oak Park, near the Athletic Ground would offer facilities for sport which would make many an old Guy's man envious. It should be possible to run it on far more economical lines than the present College, and so reduce the rate of living for the student in

residence. The whole thing would approximate far more nearly the conditions which obtain at Oxford and Cambridge, where a man seldom seems to be more than five minutes' walk from his athletic ground.

If it be granted that this establishment, which we believe would be of inestimable value to both senior and junior students, is a thing to be aimed at, then unhesitatingly it should receive the earnest consideration of the Guy's Hopital War Memorial Committee. The form which this Memorial will take is still, of course, an open question. The Committee has expressed its desire to receive suggestions, but the appeals for these that are constantly made in the GAZETTE have brought forth surprisingly little. It is therefore in the hope of arousing enthusiasm—particularly among present Guy's men—that this proposal is here brought forward. We believe that it is one with great possibilities, although at the same time in the path to its realisation lie many difficulties.

It is important to keep prominently in the foreground the main purpose of the memorial as set out in the appeal. Whether such a College as is contemplated could be regarded as a fitting memorial which should perpetuate for ever the willing service and sacrifice of Guy's men in the war, must be left for the general meeting of subscribers to decide. It is our opinion that it would come well within the scope of what is desired. What would serve better to keep fresh the memory and example of those we commemorate, than a building that is a standing benefit to students, both past and present, for generations to come?

We shall welcome all criticisms or amplifications of the above proposal, and hope that a free discussion will be promoted through the medium of the GAZETTE.

THE PUPILS' PHYSIOLOGICAL SOCIETY.

It is a matter for some gratification that so many of the Clubs' Union Societies whose activities have unfortunately lapsed during the war have been re-started so soon after the armistice. The Physiological Society only has been in something like full swing during the past four years. The Debating Society and the Dental Society have just been re-started. It is proposed to re-open the Physical Society on Wednesday, 26th February, with a Clinical evening. The exact time and place at which the meeting is to take place will be announced later. Dr. Poulton has kindly consented to take the chair, and we understand that a number of interesting cases are to be shown.

For the benefit of those who have entered Guy's Hospital since the war it may be well to give some account of the functions of the Physical Society.

The purpose of the Society is the cultivation and promotion, among the students of Guy's Hospital, of medicine, surgery, and allied subjects, and for the discussion of matters of interest in relation to medical education.

All members of the Clubs' Union are members, and all honorary members of the Union are honorary members of the Society. Before the war the affairs of the Society were managed by a committee consisting of the Honorary President, Honorary Vice-President, sixteen Presidents, and two Honorary Secretaries.

The Honorary President and Vice-President were elected from the Consulting Staff of the Hospital, the two Honorary Secretaries from the Hospital and School Staff, and the sixteen Presidents from Residents and Students.

The meetings of the Physical Society used to take place fortnightly, and consisted of Clinical evenings, at which surgical and medical cases were shown and discussed, Pathological evenings, at which pathological specimens were shown; debates, and evenings on which papers were read by members of the Society. There was a prize awarded by the Treasurer for the best essay of the year. Other prizes were

granted by the Clubs' Union for the best paper read before the Society during the session, the best case shown, the best pathological specimen, and for the member who took the best part in the discussions throughout the session.

It is proposed at the meeting on Wednesday, 26th February, in addition to the exhibition and discussion of cases, to elect officers to serve on the committee. We hope that after this meeting the activities of the Society will be set going in full swing. An institution that offers so valuable an opportunity for discussion and mutual instruction must never again be allowed to lapse into obscurity.

Guy's has been selected for the next meeting of the Anatomical Society of Great Britain and Ireland, which will be held on Friday next, Feb. 28th, at 3 p.m. All Guy's men will be made welcome, and we feel sure as many as are able will avail themselves of this opportunity. We have to congratulate Mr. Thompson, who has recently been elected Vice-President of this Society.

It has been decided to revive the Guy's Hospital Annual Dance. A committee appointed by the Residents is organising this year's dance, which will be held at Prince's Rooms, Piccadilly, on Friday, March 21st. Dancing from 9 p.m. to 3 a.m. Tickets £1 1s., including buffet supper. Any profits will be given to the Guy's Hospital Memorial Fund. Tickets and any further information may be obtained from the Hon. Sec., W. H. Cellier, The College, Guy's Hospital.

The success of the dance depends upon the support of present and past members of the Hospital and their friends. Tickets are selling fast, and all are urged to waste no time in applying.

One of the main functions of the Gazette being to report the doings of the various institutions comprising the Clubs' Union, we hail with joy the evident keeness that exists to revive many of these invaluable adjuncts to hospital life. Realising the difficulties and responsibilities of making a start, and that the initiative is largely dependant upon individual effort, we would signify our willingness to afford every support and encouragement in these pages to any genuine attempt to revive a particular hospital institution which has been suspended during the war, and which through the modesty of those who initiate and conceive its revival, might grope in darkness while some valuable months pass by.

The Dental Society has already held a meeting which we hope to report fully in our next issue. The Debating Society too has revived. One debate has been held and a secretary and committee elected. The Musical Society has made an attempt. Time was when this society—orchestral and choral—was a flourishing activity, and we hope that by next winter history will have repeated itself.

In the realm of sport, it is particularly necessary that secretaries and committees should be elected without delay. Letters are constantly coming to the hospital addressed to the secretary of this or that club dealing with various matters, especially with arranging fixtures, and there is no one to deal with them. No time should be lost in making someone, at any rate temporarily, responsible, in this direction, and here again the initiative must come from a group of men who are keen including, if possible, one who was a prominent member before the war. Cricket, lawn tennis, athletics (including cross country running with the Blackheath harriers), and swimming, at once come before our mind, and we hope that those most directly interested will feel it incumbent upom them to lead the way.

In connection with the cricket club we are asked to make an announcement. It is hoped to run one (or perhaps two) cricket teams this year. Fixtures are already being arranged. All

who wish to play should send their names in to Mr. Whitcombe, the acting secretary, so that a general meeting can be called as soon as possible notices of which will be posted up in the Colonnade. There are three or four members of the team that won the inter-hospital cricket cup in 1914, now in the hospital. This should be a good nucleus for a fresh start, and promises well for the future.

MANY will be glad to know that another Inter-Collegiate Debate has been arranged. It will be held at University College on Friday, March 7th, at 5.15 p.m. The Subject is "That the Existing Examination System should be Abolished." We feel sure that many will find this a subject upon which they can speak with surprising fluency. That it is a subject of some practical importance is shown by recent utterances of certain of our leading teachers, particularly those—to which attention has before been drawn in this GAZETTE—of Prof. Starling and Sir W. Hale White. An added attraction is that the Chairman is to be Alec Waugh, the author of that original and much criticised book "The Loom of Youth."

IN our next issue it is hoped to publish some account of the work and genius of both Sir Arbuthnot Lane and Sir W. Hale White.

Guy's Hospital Debating Society.

THE first meeting of the Debating Society was held on Thursday last, Feb. 20th, when the motion "That this House upholds the policy of strikes, and considers them a legitimate method of defence," was carried by 25 to 9. Dr. Fawcett, who was to have been in the chair, was unfortunately urgently called away at the last minute, but Dr. Ryffel very kindly stepped into the breach. Although late in the season, officers were elected. Mr. Toussaint, to whose energy the revival of this Society is largely due, was unanimously elected secretary. A full account of the meeting will appear in our next issue.

The debate was a great success, though it is unfortunate that so few of the senior men turn up.

Obituary.

2nd Lieut. NOEL MITFORD HANSON ATKINSON

Second Lt. Noël Mitford Hanson Atkinson, younger son of Dr. I. R. Atkinson. He was educated at Chigwell School, and obtained his colours for cricket and football; he won many swimming prizes, and was a colour-sergeant in the School O.T.C.

He passed the London Matriculation, and entered Guy's. After a year at the Hospital he decided on a business career and obtained a clerkship in the Hong Kong and Shanghai Bank.

On the outbreak of war he enlisted in the U.P.S. Battalion Royal Fusiliers, where he was soon after joined by his elder brother who came over from British Columbia to enlist.

In November, 1915, they were sent out to France, and spent the winter in the trenches. He became a sergeant. Early in 1916 they were sent home for commissions, were at Balliol College, Oxford, and finally posted to the East Lancs. Regt. The elder, Guy, was sent to France again in October, 1916, was wounded at the battle of the Ancre, and died of gas gangrene on October 30th. The younger, Noël, had become attached to the R.F.C., and whilst training, having passed his examinations for a pilot, was accidentally killed at the aerodrome near Cirencester on December 27th, 1916.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Rugby Football Club.

The Hon. Sec., Rugby Football Club, has received the following letter :—

St. Dunstan's,
Regent's Park, N.W. 1.
18th February, 1919.

Dear Sir,

I have received the very welcome sum of £62 17s. 6d. towards our funds, the proceeds of a Football Match played between St. Bartholomew's Hospital and Guy's Hospital, for which an official receipt is enclosed.

May I ask you to accept yourself and convey to all who participated in this kindly effort, my hearty congratulations on the result, together with an expression of very sincere and cordial thanks on behalf of the gallant men who will benefit by such practical interest in their welfare.

You will, I am sure, be interested to know that the re-education and training of these men is proceeding in a manner that surpasses the most sanguine expectations formed when St. Dunstan's was started, and that those who have left us are, with scarcely an exception, taking up their lives anew with a confidence and ability that seemed quite impossible to them in the early days of their handicap.

Yours faithfully,
E. M. BATES,
Secretary.

The Hon. Sec.
Rugby Football Club,
Guy's Hospital, S.E. 1.

Reviews, etc.

A Manual of Chemistry. By Arthur P. Luff, M.D., B.Sc., F.R.C.P. Lond., F.I.C., and Hugh C. H. Candy, B.A., B.Sc. Lond., F.I.C. Published by Cassell & Co., Ltd., London. 6th edition. 12s. net.

The First Year man frequently has difficulty in deciding what text-book in chemistry he should read. Demonstrators, enthusiasts in their own particular subject, are apt to recommend bulky volumes which contain a vast amount of information which the medical student is not expected to know, and which would be of little value if he did. On the other hand, most of the smaller books leave out much that is essential.

Here, however, we have a book that is written expressly for the medical student, and admirably does it meet his requirements. The volume is in no sense of the term a "cram" book, but on the other hand it contains no "padding." It is well arranged, easy to read, and right up to date. As a book of reference for the senior student it is excellent.

It is divided into six parts. Part I.—The Introduction to the Study of Chemistry—deals with the fundamental principles which are essential to a proper grasp of the subject in a remarkably lucid manner. This and the first three chapters of part IV. are perhaps the best parts of the whole book.

Part II.—Non-metallic Elements—and Part III.—The Metallic Elements—are models of conciseness without ambiguity. The occurrence, preparation, including manufacturing processes, compounds and tests for each element, are systematically dealt with, while its relation to pharmacy is not overlooked.

Part IV.—Organic Chemistry—contains sufficient for Part I. 2nd M.B., though this part might be expanded yet more with advantage for the student with an eye on distinction. The same clearness which is found in the rest of the book is also characteristic of this part.

Part V.—Chemical Problems—and Part VI.—Practical Chemistry—complete this little book and make it so full as to obviate the necessity of using any other book whatever.

Finally, the publishers have solved the problem of producing a volume which is handy—it will go into a coat pocket—and at the same time strongly bound and capable of lots of wear.

Pass List.

Royal Colleges of Physicians of London and Surgeons of England.

FINAL EXAMINATION.

Midwifery.—A. M. Mishad.

The following have now completed the Examination —C. H. Bubb, A. R. K. Dina, G. B. Dowling, A. A. Forty, E. J. Gaffney, C. T. Helsham, C. H. S. Horwitz, G. O. Hume, S. T. Wong, F. Young.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES.

W. G. Booth, *L. Fogelman.

*Awarded a mark of distinction in Physics.

Appointments.

R.N.M.S.

To be Temp. Surgeon, R.N. Surg. Sub-Lt. C. T. Helsham.

Surg. Lt. C. R. Cade, R.N., from R.N. Hospital, Plymouth, to H.M.S. *Cottesmore.*

Temp. Surg. A. W. Cocking has been transferred to the permanent list as Surgeon-Lieut.

R.A.M.C.

To be Lieut.-Col. Temp. Col. A. J. Hull.

Temp. Capts. (Acting Majors retaining the rank of Captains). W. A. Young, E. Evans, A. W. Ewing, J. Young, J. L. Rankine, A. N. Cox.

Capt. H. D. Smart, Acting Major, relinquishes his commission and retains the rank of Major.

Temp. Capt. C. P. Symonds relinquishes his commission on account of ill-health and retains the rank of Captain.

Papers by Guy's Men.

L. E. Stamm, B.A., B.Sc., M.D. Lond.: Medical aspects of aviation.—*Lancet*, Feb. 8th, 1919.

A. H. Tubby, C.B., C.M.G., Col. A.M.S. (in collaboration with George R. Livingstone, M.D., F.R.C.S. Edin., and J. W. Mackie, Capt. R.A.M.C.): The treatment of gunshot wounds.—*Ibid*, Feb. 15th, 1919.

Angus Wylie, M.B., B.C. Camb., M.R.C.S., L.R.C.P., Capt. R.A.M.C.: Report on the use of formalin spray in checking influenza.—*Ibid*.

Breast-Feeding, and Some of its Difficulties.

CLINICAL LECTURE BY H. C. CAMERON, M.D., F.R.C.P.

GENTLEMEN,—Every medical man in general practice must take some part in the propaganda for breast nursing, and it is important, therefore, that you should have clear ideas on the subject. If you are to persuade women to nurse their babies, you must be able to give them help and guidance in the inevitable difficulties which will occur from time to time. I know, very well, that my subject is not one on which it is at all likely that you will be examined in your Final examination. In that examination, if you cannot make a reasonably good list of the causes of aortic stenosis, or even of pylephlebitis, your hope is small indeed. But even should you be asked why women fail to nurse their infants and you have no ideas at all on the subject, you need not, I think, feel very disturbed. The question very likely has been put there only to show that the examiners realise that the physician's outlook covers other things than the study of morbid anatomy, and you will not be called upon to do more than put upon paper a few vague generalisations. In spite of this, I hope that when you are externs you will try to get some experience on these points. You will probably be in practice a long time before you encounter a case of pylephlebitis or even of aortic stenosis, but there will be many nursing mothers. You will meet with and have to combat a mass of traditional lore on this subject, almost all of which is the most complete nonsense, and which would not have survived as it has done if medical men had made it their business to undertake intelligent control. And there is one other argument which should impel you to study these matters. When you talk of pylephlebitis and aortic stenosis, there is no one to dispute your authority, but when the subject is a breast-fed baby, you have an acute and understanding critic on the question of infant management in the person of the mother herself. If you talk nonsense or show your inexperience she will not fail to detect it, and will form the lowest possible estimate, in consequence, of your whole professional attainments.

So much by way of apology, and I promise that in my next lecture I shall not forget examinations.

THREE FACTORS ON WHICH SUCCESSFUL BREAST-NURSING DEPENDS.

1. A sound technique.
2. The proper psychological atmosphere.
3. A high standard of hygiene for the baby.

1. *A Sound Technique of Nursing.*—The secretion of milk depends, first and foremost, upon the regular and complete emptying of the breast by the efficient suction of the child. All other factors are of relatively little importance. It is not well, of course, that the mother should be under-fed or over-worked, or that she should be deprived of all opportunity for exercise, but the influence exerted by these factors is small in comparison with the essential need for efficient suction on the part of the child. Women are too apt to look upon the secretion of milk as something which they themselves contribute. It would be more true to regard it as something which the healthy child provides for himself; or, if we recognise that both contentions have weight, we shall not be wrong to lay the greater emphasis on the second. If the breast is emptied completely, it fills again, as it were, to the same level and a little beyond. If, from inefficient suction, it is not emptied, the process of involution at once begins, and the milk declines

in quantity and quality alike. In general, each breast should be emptied at an interval of eight hours. In other words, feeding should be at four-hourly intervals, the breasts being used alternately. The feeding times may be 6 a.m., 10 a.m., 2 p.m., 6 p.m., 10 p.m. In a sense, however, we do wrong to lay too great an emphasis upon the importance of four-hourly feeds; it is the four-hourly sleep on which the stress should be laid. For, assuredly, if the infant is restless and wakeful and crying, the long interval of four hours will be an impossibility. The restless, crying, wriggling child grows hungry; he does more work and requires more food than does the child who is sound asleep. The treatment of this nervous unrest, which provides one of the common difficulties of breast-nursing, will be described later.

The position in which the child is held during nursing is a second point on which stress may be laid. During an air-raid, a mother was nursing an infant in the surgery. When the sound of falling bombs had passed away, it was found that the child was dead. Involuntarily the mother's muscles had tightened in her alarm, and she had held the child so closely to the breast that it had been suffocated. An incident such as this will serve to show the importance of the manner in which the child is held. It must not be pressed too tightly against the breast, as is often done; the child should lie with its head comfortably supported on the mother's knee, and her body must have sufficient forward inclination to ensure that the breast falls freely towards the child, with the nipple as dependent as possible.

2. *The Proper Psychological Atmosphere.*—It is important that the doctor and nurse should have complete confidence, from long experience, in their power to achieve invariable success under ordinary circumstances. Any hesitation, diffidence or worry will have the worst possible effect on the mother, who is always quick to catch the alarm. A confident quiet manner on the part of the nurse is of the very first importance. The secretion of milk, though less dependent than is often thought upon the mother's physique, is yet easily influenced by her mental state. We must do all that we can to create an atmosphere of calm and confidence.

3. *A High Standard of Hygiene for the Baby.*—A sound technique of nursing and a proper psychological atmosphere will only achieve success if the baby is strong, vigorous and hungry. We grown-up people know well the increased appetite, the general feeling of well-being and the sounder sleep which follow upon a long day spent in the open-air. If the baby is confined in hot rooms, over-clothed and over-heated, failure is likely to occur. In infancy, when metabolism is so active that the body weight is often doubled in three months' time, the influence of these factors is proportionately increased.

Specific Difficulties in Breast-Nursing.—We may now come to consider specific difficulties, and to discuss the means at our disposal to lessen or overcome them. We may divide them into two groups: those which concern the mother, and those which concern the child.

Factors which concern the Mother.

1. Depressed Nipples.
2. Cracked Nipples.
3. Hyperæsthesia of the Breast.
4. Mastitis.

Factors which concern the Child.

1. *Dyspnœa:* due to nasal catarrh; adenoid vegetations; deficient development of the naso-pharynx; the snuffles of syphilis; Mongolian defect; bronchitis; broncho-pneumonia; atelectasis pulmonum; congenital heart disease.

2. *Want of appetite:* due to dyspepsia from over-feeding; infection and toxæmia; icterus neonatorum.

3. *General debility and weakness:* due to exhaustion from difficult labour; prematurity; malnutrition.

4. *Interference with suction from local causes:* due to cleft-palate; hare-lip; facial paralysis; Bednar's aphthæ; ulcerative stomatitis; ranula; macroglossia.

5. *Interference with suction from general causes:* due to mental defect; spastic paraplegia (Little's disease); somnolence; nervous unrest.

I do not propose to discuss the management of every one of these difficulties; to attempt to do so in detail would, obviously, lead me too far from my subject. On some of them, however, I may usefully make some remarks.

Depressed Nipples.—I do not know the causes of depressed nipples. I am not satisfied with the suggestion that the condition is due to pressure of corsets. It is possible that the foolish custom of "breaking the nipple-strings" in infant girls may sometimes be responsible. It is a tradition among uneducated women that if the breast is to function later in life the small amount of milk which is commonly present in the breast of an infant at the time of birth must be forcibly expressed by squeezing. As a result, we often find cases of mastitis in the new-born. Much may be done in the later months of pregnancy to remedy the fault of depressed nipples, by massage and gentle traction with oiled fingers, as well as by suction with a suitable Bier's suction cup. The suction of a healthy vigorous baby itself has a great power of moulding the nipple. The infant, in suction, draws the whole areola of the breast into the mouth, and can often obtain sufficient milk from nipples which are, in themselves, small and ill-developed.

Cracked Nipples.—Cracked nipples are most frequent in depressed nipples, and after first labours. The degree of pain is very variable. I have found that the most generally useful application is a 2 per cent. solution of silver nitrate, which coats the painful fissure with a thin layer of coagulated albumen. An application of cocaine ointment half an hour before nursing, and removed just before the baby is put to the breast, sometimes controls the pain. The nipple must be carefully dried and protected with powder and absorbent wool after each nursing. The nursing for the time being should be as short as possible. Of 200 grammes of milk taken at a meal, about 150 grammes is commonly taken in the first five minutes.

Hyperæsthesia of the Nipple.—The more severe degrees of hyperæsthesia of nipple and breast are always associated with neuropathy in the mother. The nipple of a primipara, however, is often very tender and sensitive during the first days of nursing, and painting with a 1 per cent. solution of silver nitrate is often helpful.

Mastitis.—If the nipple be cracked, there is always some tendency to mastitis. Pain, redness and swelling tend to appear at the most dependent part of the breast. In order to see the part affected it is, therefore, often necessary to raise the breast and draw it forward. The treatment is to place the patient in bed upon her back, to raise the breast, and bind it with firm pressure by means of a broad bandage backwards on to the thorax. At the same time the breast should be emptied at regular intervals, either by the child's suction or by a breast-pump. The bowels should be well opened. To allow the breast to remain pendulous by permitting the mother to be up and about, to apply hot fomentations, to remove the child from the breast so as to cause accumulation of milk and fulness of the breast, are means that

are calculated to promote abscess formation. If this happens, surgical measures are necessary.

Nasal Catarrh in the Infant.—Because of the narrow air-way of a young infant, nasal catarrh readily produces nasal obstruction. It is, indeed, this tendency to nasal obstruction which makes even the simplest nasal catarrh a serious matter for a young baby, for with nasal obstruction, suction cannot take place efficiently; the nipple has to be let go in order to permit respiration by the mouth. The common complaint of mothers that the young infant is tongue-tied appears to me to be generally explicable in this way: the mother feels the faulty interrupted suction, and lights upon this fanciful explanation. As a matter of fact, the tongue takes no part in the movement of suction, and tongue-tie, even if present, is not of itself capable, therefore, of preventing suction. In cases of nasal catarrh we may help in two ways. With the head of the child thrown backwards, so that the nostrils point upwards, a few drops of alkaline lotion may be allowed to fall into the nostrils, with the object of clearing away the mucus and temporarily cleansing the passage. Secondly, we may supplement the faulty suction by means of the breast pump, and the milk so withdrawn may be given with a spoon for the time being.

Atelectasis Pulmonum.—In atelectasis, cold douching before nursing is always effective. To obtain the stimulating effect of the cold without abstraction of heat, the child should be immersed in a hot bath, from which it is momentarily withdrawn while the cold water is poured over the chest. It is then immediately returned to the hot bath.

Dyspepsia from over-feeding.—It is claimed, and, I think with justice, that by the use of the long four-hourly intervals of feeding, the number of cases of dyspepsia from over-feeding is much reduced. With frequent, two-hourly intervals there is often dyspepsia, and this may result in failure of appetite and obstinate refusal of the breast, which daily, therefore, becomes more difficult until the milk is lost. For this reason a single attack of dyspepsia in a very young infant is a grave misfortune, and care must always be exercised to avoid it.

Somnolence and Nervous Unrest.—The two last conditions which I have placed in my table of difficulties I have encountered more frequently than all the others put together. The feeble, or premature child sleeps so soundly that he is only with difficulty roused to suckle. Suction in early infancy, it is to be remembered, is not so much a voluntary as a reflex act. A finger placed on the dorsum of the tongue in a new-born child immediately evokes powerful movements of suction. Too great somnolence inhibits this reflex. The child must be constantly roused by stimuli of various sorts. Still more common is the reverse condition, in which the reflex suction act is put a stop to by the nervous unrest of the child. In the worst cases the infant, uttering its constant cry, takes no notice of the proferred nipple, and if it is placed in the child's mouth, the cry continues and no movement of suction is made. In other cases, of perhaps less severity, the nervous unrest and consequent hunger show themselves in a too-great eagerness. A voluntary suction act is substituted for the quiet, steady reflex suction, and this voluntary attempt at suction is incoordinate and ineffective. Tugging and biting at the breast, the child chokes and splutters, constantly swallowing wind, which gives rise to renewed pain and crying. In such restless, excitable children, it is apt to happen that they are nearly always fed after a considerable spell of crying, with the result that suction is interfered with, and the whole process of digestion inhibited. All that we know of digestion would make us suppose that states of such violent emotion would be accompanied by an inhibition of gastric activity. With

such children we must so manage matters that they are fed in a drowsy and quiet condition. Often all that is necessary is to put a stop to the over-stimulation that is going on in the vain endeavour to quiet the crying. All dandling, appeal and expostulation must be abandoned, and the child accustomed to lying quietly in a darkened room. When carried in the arms, it must be by someone who understands, by quiet and steady movement, how to calm and not to excite the child. Steady confident handling by a capable nurse, succeeding the timid, fussy management of the inexperienced, is often all that is wanted. In dealing with such a case a considerable latitude must be allowed to an experienced nurse or mother. By adhering rigidly to a set scheme and time table of feeding hours, in such a case, we may wreck everything. When the child's restlessness has gone we shall find that he will fall into the four-hourly routine of himself and without trouble. If necessary, sleep may be aided by small doses of bromide and chloral given some twenty minutes before meal-times; a grain of potassium bromide and a grain of chloral hydrate in 10 minims of syrup of orange with water to 1 drachm, will often be sufficient. Somehow or other, we must manage that the child sleeps well. When the mealtime arrives, the mother should quietly slip the nipple into the child's mouth, rousing him as little as possible. Then the sucking reflex will come to its own again, the breast will be drained quietly and well, and very likely the baby will go off to sleep again without waking. This condition of nervous unrest in the child with secondary aërophagy and dyspepsia is, I think, a common cause of failure of breast nursing. It is one which is very readily controlled and amenable to treatment.

The Difficulties of Insufficient Supply.—If the amount of milk remains insufficient in spite of all we can do, there remains the possibility of mixed feeding. The danger of mixed feeding must always be present in our minds. It too often happens that so soon as the child experiences the easily-running bottle, he instinctively refuses the difficult breast. Moreover, if the difficulty be due to insufficient appetite, we shall not benefit matters by satisfying a part of that appetite by artificial means. So much the less will be left for the breast. For these reasons, we must always consider the matter very carefully before we advise the institution of mixed feeding. Speaking generally, it is a course which is often too lightly entered upon, and which is in many cases directly responsible for the drying up of the breast and the institution of bottle-feeding. It is safer, when possible not to use a bottle at all, but to give the additional food from a spoon. Mrs. Stuart-Robertson, who is good enough to help me in the Department, has had good results by making use of a supplementary feeding, which consists of a teaspoonful, or more, of undiluted condensed milk given in a spoon after nursing. To give milk in this condensed form is, perhaps, physiological, because, as you know, the last milk expressed from the breast is many times richer in fat than is the milk first drawn. The so-called "strippings," that is, the last milk from the cow after milking, may contain as much as 15 per cent. of fat. In many cases it is probably the absence of the last concentrated milk which is the cause of the child's undernourishment.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Scabies and Pediculosis Corporis.

By H. W. BARBER.

These two parasitic affections of the skin, formerly of comparatively minor importance, presented one of the greatest problems with which the army medical authorities had to deal during the war, for they unquestionably proved the commonest causes of temporary disability among our troops in France. Indeed, had it been possible to stamp out entirely the body-louse and the itch-mite in early days, the enormous saving in man-power that would thus have been attained might conceivably have materially altered the course of the war; for it must be remembered that the body-louse, apart from being the exciting cause of severe and obstinate skin-lesions has been proved to convey the infecting organism of Trench Fever, the number of casualties from which was very great.

The prevalence of scabies and pediculosis corporis in the army has greatly increased the incidence of these diseases among civilians, for, although men going on leave to the United Kingdom from France are submitted to inspection by a medical officer, such a measure is manifestly inadequate to prevent the conveyance of the parasites to civilian homes. As Thibierge has pointed out, the number of cases of scabies treated in the Paris hospitals in 1917 was more than three and a half times greater than in 1913, and among the better classes the incidence of the disease was ten times greater. And, with regard to pediculosis corporis, it was rare before the war to see cases—even among hospital out-patients—of severe pyodermia with ecthyma, such as were so common on active service. Indeed, the first case that came to my notice—that of a soldier returned from France early in 1915—puzzled not only myself, but several dermatologists of wide experience, who also saw the patient.

Such cases will doubtless continue to be met with in the United Kingdom for some time to come, so that perhaps a short account of the characteristic features of scabies and pediculosis corporis, with some suggestions for their treatment, may be of use to those who have not had much opportunity of studying these diseases.

Scabies.

Ætiology.—It is not necessary to enter into a detailed description of the acarus (or sarcoptes) scabiei, but the following points as to its life-history are of importance:—

1. The female is the predominant partner in the production of the disease, and is considerably larger than the male.

2. After impregnation she burrows in the epidermis, forming a tunnel or "burrow," in which she lays her eggs, and at the extremity of which she lives. It is thought that she never again leaves her burrow, and, having laid her eggs, she dies. The male does not burrow, but may be found with difficulty under the edges of epidermal scales or crusts.

3. From the eggs larval forms emerge, and escape either through the original point of entry of their mother, or through a hole in the roof of the burrow. The larvæ themselves burrow for a short time while they cast their sloughs, and then gradually assume the adult form. The males probably die soon after copulation; the female is said to live from 20—60 days and during this time lays from 20—50 eggs.

Spread of Infection.—The most usual method of contracting the disease is unquestion-

ably by sleeping in close contact with an infected person, though there is no longer any doubt that infection may occur by means of blankets, sheets, and perhaps mattresses. Soldiers on leave bring the parasite contracted at the front, transmit it to their wives and children, and leave it in the bed-linen of home or hotel, which, unless carefully washed, serves to disseminate the disease further.

Ordinary contact with an infected person during the daytime is hardly ever sufficient to transmit the parasite, and medical men practically never acquire the disease from their patients. I have myself examined several thousand cases of scabies, and have never been infected. This is probably because the acarus is inactive except in very warm surroundings, as may be proved by placing one on a cold glass slide, where it will remain motionless; but, if the slide be warmed, it will begin to move at once. The warmth of the bed provides the usual stimulus, and this is why patients with scabies say that their itching begins "as soon as they get warm in bed."

THE ERUPTION of scabies is essentially polymorphic, and varies greatly according to the individual idiosyncrasies and habits of the infected person. It is obvious, of course, that the disease will be more widespread, and secondary pyogenic infection of the abraded skin more severe, in those of dirty habits than in those who value personal cleanliness, and this fact partly accounts for the very severe cases of scabies met with among officers and soldiers on active service, many of whom, unable even to take off their clothes for several days and unwilling to report sick, "carried on" until their skin was covered with sores and boils; in such cases cellulitis, associated with considerable systemic disturbance, not uncommonly supervened. But, apart from this factor of personal cleanliness, the extent and severity of the eruption depends on the susceptibility of the infected person. This fact has not been sufficiently appreciated.

The irritation in the skin produced by the acarus is not merely (if, indeed, at all) due to its burrowing activities, but to some irritant secreted by it, perhaps a kind of saliva. Whether this substance is actually absorbed by the host or not it is difficult to say, but the fact that infection with scabies is followed by a specific cutaneous reaction—namely, erection of the pilosebaceous follicles—over a wide area, and in regions where actual burrows are seldom found, suggests that this may be the case. On the other hand, as the follicles on the face do not take part in this reaction, the contrary may be argued. In any case, this follicular erection, which is usually particularly well seen on the abdomen, is a most characteristic feature of a well-developed scabies eruption, giving to the skin a peculiar "goose-skin" appearance, and it can only be explained by supposing that the acarus secretes some specific toxin, for it cannot be a mere reflex result of irritation, since other sources of irritation, *e.g.*, pediculi, do not give rise to it.

The primary lesion of scabies is, of course, the "burrow." This is a linear lesion, often distinctly elevated, so that it may be felt by the finger as a distinct ridge, of a yellowish or greyish colour (black in soiled skin). The point of entry of the "burrow" is more prominent than the other or deeper end, where the female acarus may often be recognised as a small white speck, shining through the epidermis. Along the course of the burrow a series of black dots are usually seen—representing the fæces—and, on examining an excised "burrow" under the microscope, the eggs and larvæ, in various stages of development, can be studied. In shape the "burrow" may be simply curved, or angular, or S-shaped; usually only a few

millimetres in length, burrows of two inches have been recorded.

The secondary lesions of scabies are various, and depend largely on the individual infected. In an ordinary case of moderate severity, perhaps the most striking feature of the eruption, as a whole, is the follicular erection already referred to; it will be observed that the pilosebaceous follicles stand out, particularly in certain situations such as the abdomen, thighs, and forearms; many are inflamed from secondary infection, and at the apices will be seen pinpoint blood-crusts, the result of scratching. The picture formed by these scratched, inflamed follicles is highly characteristic, and forms a striking contrast to that seen in pediculosis, where there is no follicular erection and the blood-crusts are typically linear.

Apart from this generalised follicular erection, a variety of other lesions—vesicles, pustules, papules, and superficial crusted ecthyma—are commonly seen. In infants and young children large bullæ are often formed, especially on the hands and feet. Particular attention should be drawn to elongated, hard, red infiltrations, formed along the course of burrows, and best seen on the anterior axillary folds, round the nipples and navel, and on the penis; similar in character to these are the chronic prurigenous papules, occurring chiefly on the scrotum, wrists, and buttocks, which may persist after the actual cure of the disease.

DISTRIBUTION.—Familiarity with the typical distribution of the eruption of scabies is essential in order to prevent errors of diagnosis, since in many cases it is difficult or even impossible actually to demonstrate the burrows. It is positively astounding how frequently scabies is overlooked, and a diagnosis of "urticaria," "eczema," or "furunculosis," made; and it is hardly surprising how refractory such cases prove to treatment! I recently heard of a man who had been treated for "furunculosis" with injections of colloidal manganese, when he was really suffering from scabies. And yet, so characteristic are the appearance and distribution of the lesions, that it is often possible to diagnose the disease with certainty by inspecting, say, the skin over one elbow-joint.

It is useful to remember Hebra's dictum that, with the patient's arms hanging by his sides, the greater part of the eruptive lesions of scabies can be recognised between two parallels, one drawn through the nipples and the other a short distance above the knees.

The most important sites are as follows:—*the hands*, particularly in the interdigital folds, along the ulnar borders, and on the lateral aspects of the fingers, *the anterior surfaces of the wrists*, *the elbows*, *the anterior folds of the axillæ*, around *the nipples*, particularly in women, *the umbilicus and abdomen*, *the penis and scrotum*, *the lower half of the buttocks*, *the thighs*, and *the ankles and feet*. It must be remembered, however, that frequent washing of the hands may cause these parts to be spared, and I have myself learnt to rely more on the appearance of *the elbows*, *anterior axillary folds*, *penis*, and *lower half of the buttocks*. In adults the face, practically speaking, is never involved, but in infants it may be affected from contact with its mother's breast. Burrows are most easily found on the fingers, wrists, elbows, penis, and heels.

COMPLICATIONS OF SCABIES.—There must now be considered certain secondary complications of scabies, which would seem to depend on individual idiosyncrasies. In order to understand these it must be realised that certain people present a special cutaneous reaction both towards external irritants and to poisons absorbed from within, and that this reaction differs in type in different persons. Thus we find that those who are subject to *urticaria* will

react in this way to scabies and to body-lice, so that "wheals" will be mixed with the other lesions of their eruption, and the distribution of these wheals will tend to follow the characteristic distribution of the two diseases.

[I recently saw a boy who had an eruption of urticaria chiefly situated over his shoulders, the lower part of his back, and on his thighs; his skin was also pigmented over these areas, and showed linear scratch marks. I had no difficulty in finding several body-lice in his clothing, and on questioning his mother I was told that the boy had for many years been subject to outbreaks of "itching white blisters." Here, then, was a case of urticaria, in which the attack that I observed was presumably provoked by lice, since the wheals were most evident on the "sites of election" of pediculosis, and were accompanied by pigmentation of the skin and linear scratch-marks; but some at least of the previous attacks were in all probability of alimentary origin.]

A more important type of reaction is the *eczematous* one; it is seen in seborrhœic persons, and is so constant that, if such a person be infected with scabies for any length of time, one can predict with certainty that the eruption will be complicated by an outbreak of seborrhœic eczema. Here, again, the distribution of the eczematous areas will follow to a certain extent that of scabies, but, as with all seborrhœic eruptions, the flexures tend sooner or later to be involved.

In a suitable case the evolution of the eczematous patches may be followed. The eruption begins as a discrete papulo-follicular eczema confined to the erected pilosebaceous follicles already described; later, confluence takes place by the eczematisation of the intervening skin, the discrete follicular appearance is lost, and diffuse patches of eczema, which may coalesce to form large plaques, make their appearance.

Scabies, then, is a most potent agent in provoking an outbreak of generalised seborrhœic eczema in a person of the seborrhœic type, and the association is a very important one, not only in that it is apt to lead to an error of diagnosis—the eczema being recognised, and the scabies overlooked—but because it renders the treatment more difficult, and greatly prolongs the convalescent period.

Secondary pyogenic infection in scabies partly depends, as has been pointed out, on lack of personal cleanliness, but experience amongst soldiers in France showed that it was always most severe and intractable in seborrhœic persons. In them superficial pustules, purulent bullæ, deep boils, and even cellulitis were the rule, and severe adenitis in the axillæ and groins, with secondary abscess-formation, was not uncommon. Cases were frequently seen in which there was acute impetiginised seborrhœic eczema of the face and scalp, and scabies of the body, complicated by severe pyogenic infection and secondary eczematisation. The skill and patience required in treating such cases can well be imagined, and the period of disability was necessarily often very long.

Finally, the association of scabies with *psoriasis* deserves passing mention. Just as an attack of scabies in an urticarial or seborrhœic person will provoke an outbreak of wheals or of eczema, so in one subject to psoriasis infection with the acarus may apparently lead to an attack of this disease, and here again the distribution of the psoriasis lesions is determined to a great extent by the accompanying parasitic infection. Several cases, in which the two diseases were associated, came under my observation among soldiers, and, being aware of the fact that in a person suffering from psoriasis new lesions may be produced by scratching or

irritating healthy parts of the skin (witness the involvement of operation scars), I was of opinion that the patients had already active psoriasis when infection with scabies occurred, and that the consequent scratching produced fresh lesions. But I have recently seen a case which suggests that scabies may produce a fresh outbreak of psoriasis in a psoriatic subject, although *no actual lesions were present on the skin at the time of infection with the parasite*. The patient was a woman who had had several attacks of psoriasis, and she acquired scabies from her husband when he was on leave from France. At this time, she declares positively she had no lesions of psoriasis whatever on her skin, but they began to appear on her wrists and arms some days after her itching commenced. She came to hospital with her baby, who had also acquired scabies, and when I saw her she had a mixed eruption of psoriasis and scabies, but it was very noticeable that the distribution of the psoriasis lesions was most evident in the scabies situations, namely, on her wrists, forearms, anterior axillary folds, elbows, abdomen, thighs, lower half of the buttocks, and ankles. Neither her scalp nor her knees were affected, nor were there any lesions on her back. She herself was convinced that the scabies had produced a fresh attack of her psoriasis.

The Diagnosis of Scabies.—If what has been said about the distribution and character of the eruption be borne in mind the diagnosis of scabies is not, as a rule, difficult. In a doubtful case the fact that the itching is usually only present at night-time, or when the patient is heated, is often helpful (though, of course, itching due to lice is also worse at night), as also is the elicitation of the information that other members of the household are affected. It should be remembered that scabies is often contracted during sexual intercourse, and cases are frequently encountered in which the lesions are confined to the genital regions; it is, therefore, of the utmost importance to be familiar with the appearance of scabies on the penis. In this connection may be mentioned the fact that such lesions are all too frequently diagnosed as soft sores or as syphilitic chancres, but, on the other hand, syphilis and scabies not uncommonly co-exist, and one or more chancres may develop on abrasions originally produced by scabies. In the same way a secondary syphilitic rash may be intermingled with the scratched lesions of scabies, and this may lead to an error of diagnosis, because a syphilitic eruption is seldom irritable. But careful examination of the mucous membranes should prevent a mistake being made.

Cheiropompholyx or dysidrosis was frequently mistaken for scabies among troops in France, and, since this affection involves chiefly the hands and feet—particularly the lateral aspects of the fingers and toes—the error is not unnatural. The eruption consists of little vesicles, at first deeply embedded in the skin so that they resemble sago-grains, which may become superficial and coalesce to form bullæ. They contain a clear, neutral or slightly alkaline fluid, becoming later turbid should secondary infection occur, as is likely to happen on the feet. The lesions seldom burst spontaneously, but usually dry up in a few days, whereupon the epidermis exfoliates and is cast off, leaving a smooth reddened surface.

The condition is not, as has been thought, a disease of the sweat glands or ducts, but is essentially an eczema, the somewhat peculiar appearances of which are apparently due to its situation.

Certain persons are subject to periodical spontaneous outbreaks of this affection, but eruptions, having exactly the same clinical and histological appearances, may be produced artificially on the hands and feet of some people by external irritants, *e.g.*, by sulphur, poison-

ous plants, etc., and *by scabies itself*. I have seen several cases of scabies accompanied by typical lesions of pompholyx (apart altogether from the ordinary vesicles met with in scabies), and I have also observed the condition arise after treatment with sulphur. These cases nearly always exhibited eczematous lesions elsewhere, and, apart from scabies, pompholyx of the hands was frequently seen in soldiers with seborrhœic eczema of the face and body. My own opinion is, then, that pompholyx is simply a variety of eczema, which owes its clinical characteristics to the special sites on which it appears, and that, like eczema, it may appear *de novo* from some toxic product of faulty metabolism, or may be produced by external irritants.

From what has been said it is evident that the differential diagnosis of the condition from scabies depends on a search for burrows, and on a complete examination of the body for other evidence of scabies.

The well-known "Prickly Heat," or *miliaria rubra*, may be mistaken for scabies, but the eruption, which consists of innumerable tiny red spots, is chiefly situated upon the chest, abdomen, back, and arms. In most cases an attack is rapidly cut short by applying a dusting powder locally, and giving saline purgatives and diuretics internally. *Urticaria papulosa* in children may also be confused with scabies, but there is usually a history of recurrent attacks over a long period, the child's skin is often clear during the daytime, and the hands and genital organs are seldom affected. But it must be remembered that scabies will provoke an outbreak of the urticarial lesions in a child so disposed, and I have frequently seen the two diseases co-existing.

The differential diagnosis between scabies and *pediculosis corporis*, and their treatment, will be considered later.

(To be concluded.)

Honours.

Bar to M.C.

Temp. Capt. H. L. Messenger, M.C. For conspicuous gallantry and devotion to duty on September 18th, 1918, near Doldejeli. He led a party of stretcher-bearers some 400 yards across the open, through a heavy barrage, and succeeded in rescuing and bringing in a large number of casualties to his advanced post.

The next day he established touch forward with the attacking battalions under heavy artillery and machine-gun fire. Throughout the action he showed the greatest energy and disregard of personal danger.

M.C.

Temp. Lieut. C. Dean. For conspicuous gallantry and devotion to duty at Holnon during the operations of September 17th and 19th, 1918.

Although suffering from a sprained ankle he was untiring in his efforts to collect and attend wounded. He was constantly exposed to shell-fire, but took no notice for himself, though he made his stretcher-bearers take cover.

Mentioned in Despatches.

The names of the following Medical Officers are mentioned in despatches :—

R.A.M.C.

Temp. Lieut.-Col. C. M. Wenyon, C.M.G.
Temp. Capt. J. A. Delmege, O.B.E.
Temp. Capt. N. E. Kendall.

EAST AFRICAN FORCE.

Lieut.-Col. A. D. J. B. Williams, E.A.M.C.
Temp. Capt. C. R. Howard (died).

DECORATIONS (FRENCH).

Médialle des Epidémies (en argent) Capt. E. S. Taylor, R.A.M.C.

Change of Address.

Capt. (Acting Major) G. H. Thomson, I.M.S., 48th Indian General Hospital, Salonika.

Capt. R. Curle, from 2nd Southern General Hospital, Bristol, to Holmesdale, Leamington Spa.

Birth.

WHEELER.—On February 2nd, 1919, the wife of Capt. F. J. Wheeler, R.A.M.C., T., of 41, Albert Road, Southport.—Twins (daughters).

Marriages.

PENNY—SCOTT.—At St. Thomas Cathedral, Bombay, on December 30th, 1918, by the Rev. J. L. C. Dart, Capt. (Temp. Major) Edward Austin Penny, Indian Medical Service, eldest son of Dr. and Mrs. Penny, Marlborough, Wilts, to Lilian Margaret Scott, eldest daughter of the late Samuel Scott, Esq., Colwich, Staffs.

G. B. D.
G. P. L.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 800.] MARCH 8, 1919. [SIXPENCE.

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Passim.

WITH regard to the proposal that the Guy's War Memorial should take the form of a Residential College at Honour Oak Park, which was put forward in these columns of our last issue, we are glad to say that it has met with a welcome response. On another page will be found several letters we have received dealing with the subject, and in every one of these the suggestion has been received most favourably. The opinions expressed by our correspondents serve to show—indeed, we feel sure it is a matter of general agreement among students here—that such a hostel as has been outlined is an urgent necessity. And there can be very little doubt that such an institution would be welcomed and patronised by junior men. The advantages to senior men in the wards are as obvious as the advantages to those who would be resident in the Memorial Hostel.

Mr. Bull had actually begun to draw up a similar scheme before the war. We can think of no reason why the keenness of junior dental men now should not be just as unanimous as it evidently was five years ago. We have heard the objection raised that there is no guarantee that such a Hostel would be popular and that men might not want to reside there. Mr. Bull's evidence effectively disperses this objection, which we are inclined to think is more imaginary than real. The same correspondent reminds us that the experiment has been tried by University College.

There is very little doubt that a Hostel not only would be a lasting benefit, but is an urgent necessity. That the scheme is practicable is probable, but open to argument. The main point at issue, however, is whether or not it would be a fitting memorial to the great spirit of sacrifice which we desire to commemorate. It is in this direction that we anticipate most criticism. It may be said, for example, that the Memorial should be in the precincts of the Hospital itself. But this should not be an insuperable objection. Meanwhile, we entirely agree with the convictions which the President of the Residents has expressed in his letter, and, emboldened by the support already received, we continue to be of opinion that this is the most suitable and practical proposal for a Guy's War Memorial that has yet been put forward.

IT is our pleasure to record two most enjoyable dances that have taken place in the Court Room. The thanks of all are due to the hostess, Lady Perry, for her great kindness. The band and condition of the floor left nothing to be desired, and both dances were unanimously voted a great success.

A meeting of the Pupils' Physical Society took place on Wednesday, 20th February. The meeting was well attended, and all who were fortunate enough to be present spent a most enjoyable evening. A number of very good cases were exhibited in the Clinical Lecture Theatre and in the neighbouring Theatres.

Dr. Poulton, who kindly took the chair, opened the discussion with a brief account of the traditions and aims of the Society. The meeting then elected Mr. J. Joffe and Mr. W. H. Grace as Honorary Secretaries.

So keen was the ensuing discussion on the cases that, although the meeting was prolonged for over an hour beyond the scheduled time, it was not possible to get through more than half the cases.

Of those present who were fortunate in being members of the Physical Society before the war, all were agreed that the meeting was well up to the standard of pre-war excellence. Opinion is universally in agreement that the Physical Society's meetings must be continued without any future break. We understand that the next meeting is to take place on Thursday, 13th March. All those who can possibly turn up should not fail to do so as it is desired to elect a fully representative committee.

Attention is again drawn to the Guy's Hospital Ball, to be held at Prince's on March 21st. This used to be the chief social function of the Hospital winter, and in view of the present vogue for dancing, it should be a tremendous success. The task of arranging so large a function is no sinecure, and deserves much more active support from all Guy's men. Lady Fripp has kindly consented to be hostess.

It is difficult to express with what pleasure one and all are welcoming the return to Guy's of those members of the Staff and other Guy's men who have been away on war service. We are happy to note the return during the past fortnight of Lieut.-Col. T. B. Layton and Major G. T. Mullally, who have been on active service since 1914.

"The number of doctors in the army last November was 11,000. The number at present is 9,593." (Mr. Churchill in the House of Commons, March 4th, 1919.)

Here are two statements of fact which deserve to be put side by side, because they have such an obvious relation to each other. It is to be hoped that the promise Mr. Churchill made later that medical men will be demobilised at an increasing rate will be carried into effect without any more delay.

We are asked to announce specially the Ladies' Night of the Debating Society, which is fixed for Thursday, March 20th, at 7.30 p.m. Dr. Fawcett is to be in the chair. The subject, "That in the opinion of this house the time has now arrived when women should have economic independence on the same basis as men," will be opened by a speaker from Girton. Other women's colleges will be represented, and we understand several members of the staff have signified their intention of being present.

This promises to be a most successful evening. All Guy's men and their friends will be welcome. Further particulars will be posted in the Colonnade.

Applications are invited for the Arthur Durham Travelling Studentship of the value of £100. Copies of Extracts from the Regulations governing the Studentship may be obtained at the Medical School Office. Applications should be sent to the Dean, at the Medical School Office, on or before the 31st March, 1919.

We have pleasure in announcing that after April 30th, the Chemical Laboratories in the Medical School, which have been used for the benefit of the Ministry of Munitions during 1916–17–18, will again be available for the use of the Physiological Department. The following letter has been received by the Dean of the

Medical School expressing the appreciation of the Ministry of Munitions of the valuable work that has been done at Guy's under the directorship of Professor Lowry:—

The Controller of Gun Ammunition Filling,
Ministry of Munitions of War,
28, Northumberland Avenue,
W.C. 2.
23rd January, 1919.

To the Dean of the Medical School,
Guy's Hospital, London, S.E.

Dear Sir,

In view of the winding up of the Experimental Work of this Department and the dispersal of the Experimental Staff, it is proposed to vacate after Easter the Laboratories at Guy's which are now occupied on behalf of the Ministry of Munitions. I therefore beg to give notice to terminate the present agreement on April 30th, 1919. In doing so I wish to express my appreciation of the services which you have rendered to this Department by allowing us to make use of the accommodation of the School at a time when the provision of fresh Laboratory accommodation has proved extremely difficult. I shall be glad if you will also covey to your colleagues my thanks for their concurrence in the arrangements that have been made for carrying on our work in the School.

Yours faithfully,
L. C. P. Milman, Brig. Gen.
Controller of Gun Ammunition Filling.

"Gazette" Museum of Antiquities.

Presentation by Capt. W. H. Ogilvie, R.A.M.C.

Capt. W. H. Ogilvie, R.A.M.C. has very kindly presented to the "Gazette" Museum of Antiquities an Austrian Army Stretcher which was left behind during the last Piave Battle at Sacile, Italy.

It forms a very interesting addition to the Museum, and we venture to hope now that the War is over other "Guy's men" may be induced to follow Capt. Ogilvie's example.

We are glad to find that justice is to be done to Army Dental Officers, and they are not to be deprived of their well-earned service gratuities.

The Executive Committee of the British Dental Association has been officially informed that an Army Council Instruction will be published shortly granting a gratuity at the rate of £50 for each complete year's or part of a year's service.

Appointments.

R.N.M.S.

The following appointments have been made:—

Surg.-Commandr. C. M. Beadnell has been promoted to the rank of Surg.-Capt.

Surg.-Lieut.-Commandr. A. E. P. Cheeseman has been appointed to the *Ceres*.

R.A.M.C.

Brevet Major to be Major.—H. G. Gibson.

Capt. to be Major.—W. B. Purdom.

To be Acting Majors.—Capts. H. W. Elliott, R. W. P. Jackson, W. H. S. Burney, J. S. Steele-Perkins.

Temp. Major J. C. Davies relinquishes the acting rank of Lieut.-Col. on reposting.

Officers relinquishing their Commissions.—The undermentioned relinquish their Commissions on ceasing to serve with No. 8 British Red Cross (Liverpool Merchants Mobile) Hospital, and retain their hon. rank.—Temp. Hon. Capt. H. W. Jones, Temp. Capt. A. Leeming.

Capt. J. Walker relinquishes the acting rank of Major on reposting.

Special Reserve of Officers.

Lieuts. to be Capts.—A. Bulleid, D. V. Halstead, J. R. Cox.

R.A.F.

G. McK. Thomas is granted a temporary commission as Lieutenant.

Capt. L. G. Davies relinquishes his commission on account of ill-health, and is permitted to retain his rank.

Capt. H. M. S. Turner is granted the rank of Major.

Honours.

O.B.E.

Dr. G. E. Genge-Andrews, Dr. M. A. Key. Mr. J. H. Harvey.

Obituary.

Capt. NOEL HUMPHREY WYKEHAM SAW.

Capt. Noel Humphrey Wykeham Saw, M.C., R.A.M.C., attached Worcestershire Regiment, who was killed in action on the 9th October, 1917, aged 25, was the younger son of Mr. and Mrs. Saw, junior, of 11, Vanbrugh Park Road, Blackheath, and grandson of Mr. Samuel Saw, senior, of Glenluce Road.

He was educated at Stratheden House School and Cheltenham College (Newick House), and belonged to the College O.T.C. On leaving Cheltenham he became a student at Guy's Hospital, and joined the Artists' Rifles, of which he remained a member for four years, resigning early in 1914 to devote himself entirely to his last year of medical study. He played football for Guy's and Blackheath, and was a good runner in the mile and half-mile.

On the outbreak of war he applied to rejoin the Artists, but was advised to complete his medical course in October if possible. He became fully qualified as physician and surgeon in February, 1915, and at once joined the R.A.M.C. (Special Reserve), and in July was sent in charge of troops to Mudros. Becoming attached to the Worcestershire Regiment (29th Division) he went to the Gallipoli Peninsula and remained there until the end, taking part in both evacuations at Suvla Bay and Cape Helles. After some months in Egypt and at Suez the Battalion came to France, and Capt. Saw was present at the Battle of the Somme, where, in recognition of his gallantry during the first five days of July, he was awarded the Military Cross. He saw much service in France and Flanders, and met with his death on the battlefield whilst tending the wounded on the 9th of October, 1917.

From a letter sent by one of the officers, it appears that "very early in the battle a shell landed right in the door of the Aid Post and he was killed instantly. . . His long connection with the battalion, his sharing of all its vicissitudes and dangers, his even, cheery disposition, and, above all, his utter unselfishness, endeared him greatly to us all. . . His friendship and the memory of his life will long be a powerful inspiration to those who knew him."

He was buried on the 11th October at the British Military Cemetery at the base.

JOHN STANLEY COCKS.

To many Guy's men the news of the death of J. S. Cocks at Beyrut following typhus will be a source of profound regret. Those who knew him intimately will mourn one of those rare and lovable characters whom it is a privilege and a pleasure to know. Those who knew him more casually will miss the merry, quaintly humorous, yet withal serious, figure of their hospital days.

My first recollection of Cocks is of a small boy (I did not think him so, being of the same age myself) in brown knickerbockers and stanley jacket at a small private school in our native town. Our subsequent school careers lay

apart, and save for the holidays we saw little of each other. We met again at Guy's, and for some four and a half years lived together in the same diggings. It was in those years that the light friendship of boyhood's days ripened into the firm, and I dare to think, unbreakable friendship of manhood. It was then I learned his true worth. The singleness and simplicity of his character, his earnest and unostentatious piety, his utter unselfishness and unruffled good temper.

You couldn't quarrel with Cocks. Quarrelling and bickering was totally foreign to his nature. He would stick to his point like a leech, but I cannot recollect ever seeing him lose his temper. His mode of defence or retaliation was a quaint jest or whimsical remark, totally disarming. Sweetness was the very essence of his personality.

He was decidedly a shy and sensitive man. On first acquaintance he often passed as a quiet, retiring fellow of no very remarkable parts. What a tremendous misconception! He had force and determination the casual observer would never dream he possessed. If Jack Cocks made up his mind to do a thing nothing I know of would deter him. I mean provided he thought it the right and proper thing to do. He wouldn't argue about it or explain, but simply did it.

I remember that when reading for his examinations he would set himself to read some work or other from cover to cover. You might plead any diversion you liked, it made no difference, that book was read right through. That was characteristic of the man.

He, perhaps, never shone pre-eminently either in work or play, but that was simply because he never hankered after notoriety. Both were thoroughly and conscientiously done and always brought to a successful conclusion. He was quick to recognise and unstinted in his praise of merit in others, but neither looked for nor asked approbation for himself.

His humour was all his own. Trite and witty remarks flowed from him in endless profusion. He would parody any and every imaginable thing. He could pour out a never-ending stream of the most inimitable patter. I have seen him many a time have the whole roomful rocking with laughter by the hour on end, and never as much as a smile on his own face. When he greeted you it was with a funny remark and quaint antic or gesture. Oh, he was the merriest, jolliest companion ever man lived with; welcomed and loved wherever he went, the life and soul of every party, and of a winsome gaiety that infected everyone.

And now he lies among the pine trees, under the Syrian sun, the whitest soul that ever graced this earth, the sweetest, most loyal friend ever man had.

"His life was gentle, and the elements
So mix'd in him that Nature might stand up
And say to all the world: This was a man."

A. B.

Change of Address.

Major T. F. Brown, D.S.O., A.A.M.C., from 3rd Australian Auxiliary Hospital, Dartford, to "Ararat," Victoria.

Lieut.-Col. Nicholson, R.A.M.C., from St. Ignatius Hospital, Malta, to Fortress Headquarters, Malta.

Capt. E. Morgan, R.A.M.C., from Deccan Hospital, Poona, India, to Groombridge, Sketty, R.S.O., Glam.

Lieut.-Col. W. L. W. Marshall, C.M.G., J.P., from War Hospital, Huddersfield, to Oakhayes, Woodbury, Devon.

(The Editor will be very glad to receive a post card with notes of any change of address.)

Papers by Guy's Men.

Sir W. Arbuthnot Lane, Bart., M.S., F.R.C.S.: Chronic intestinal stasis. What are the indications for operative interference?—*Lancet*, March 1st, 1919.

Guy's Hospital Physiological Society.

Sex Determination.

Paper by Mr. A. MACKENZIE.

The abnormal destruction of males which has taken place in the last four years has rendered the question as to whether it is possible to predetermine the sex of a child one of extreme interest, both nationally and individually.

Theories regarding this question have been formulated from the earliest times. The chief theories, chronologically arranged, are here appended :—

(1) Hippocrates' theory was that there were two kinds of generative elements, strong and weak: the strong producing males and the weak, females.

(2) Galen considered that the right side of the body was warmer than the left: the semen of the warmer side produced males; the colder, females.

(3) The antagonism theory next held the daïs. It postulated that there was a struggle between the male and female elements, and the stronger produced its own sex.

(4) The alternative ovulation theory now came into prominence, according to which ova are liberated of male and female sex alternately, and the sex is determined according to which ovum is fertilised.

(5) Heule's theory was that each testis (and ovary) produced spermatozoa (or ova) of different sex.

(6) Felhin and Vilson confined their observation to climatic and nutritive conditions, and deduced that in adverse circumstances females were produced to excess.

(7) An example of Mendelian inheritance is given in the method in which hæmophilia is inherited, which is, roughly, as follows:—

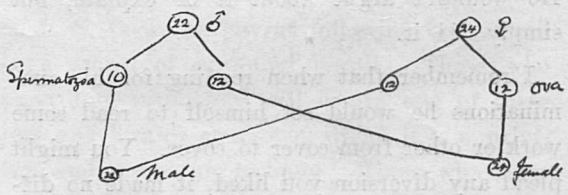
Affected men marrying normal women have normal children. The daughters, however, though themselves normal, transmit the tendency to their male offspring.

The explanation lies in the theory that there is a lack in the generative elements of the hæmophilic male, which, *when transmitted to the female*, produces normal males and apparently normal females, who, nevertheless, have a corresponding lack which in the next generation shows itself in the males.

(8) Shenk's theory was founded on the nutritive condition of the female.

(9) The most modern theory of all is the X-chromosome theory. It has been found in various animals, and indeed in man, that certain spermatozoa contain more chromosomes than others, the extra chromosomes being called the X-chromosomes or heterotype-chromosomes. Take the case of man. Spermatocytes produce an equal number of spermatozoa with 10 chromosomes and with 12 chromosomes. Every male adult cell contains 22 chromosomes and female cell contains 24 chromosomes. The ova contain 12 chromosomes. The theory is that 10 chromosome spermatozoa + 12 chromosome ovum produces a male and 12 chromosome spermatozoa + ovum produces a female.

Diagramatically :—



This theory is now receiving much attention, and is considered to be the only credible one.

Mr. T. J. Evans, who kindly took the chair, added to Mr. Mackenzie's paper the results of the very latest researches on the theory, and added his own quota to the evidence in sup- of the theory. The phenomena of reproduction in the litomastia (a parasite of the butterfly)

one large egg breaking up into thousands of smaller eggs producing larvæ *all of the same sex*, and in the nine-banded armadillo (satusia) where four fœtuses are attached to one placenta and derived from one ovum, again all of one sex, seem to bear out the theory.

Mr. Maizels, however, most emphatically denied the practicability of the theory, quoting, among other examples, artificial pathenogenesis, sex of young bonellia (marine worm) where those which adhere to the maternal snout (sic) are female and the others are male; gynandomorphism, and the method of reproduction of tænia, first segments female later segments male as being direct negations of the possibility of the correctness of this theory.

Others also brought forward various more or less obscure cases, where the reproductive mechanism apparently contradicted the theory.

In defending the theory against these attacks the chairman said that artificial pathenogenesis, which is successful in less than one case in a thousand, has never succeeded in producing an adult animal, and where larvæ have been produced, it has been extremely difficult to deduce anything regarding their sex.

In the case of bonellia (marine worm), it is the females which, being stronger, survive and are able by virtue of their extra strength to attach themselves where conditions are most suitable for their development—the snout of the mother!

The case of the tænia was not a case in point, as it proved nothing either for or against the theory.

The chairman added that the cases were all extreme cases, and it was unfair (even if they did apparently contradict the theory) to bring up extremes and to put them forward as rendering a theory supported by such a mass of evidence as this was, null and void. Sea, after all, was a more or less variable thing and was capable of great vicissitudes and therefore liable to a great many exceptions to any hard and fast rule.

Mr. Hodgkinson, quoting the *Lancet*, and Mr. Rogers, quoting the B.M.J., put forward a theory enunciated in these journals, that ova became progressively weaker in their passage from the ovaries to the exterior, the weaker ova when fertilised giving rise to females and the stronger to males. Several people were said to have proved this by experiment. However,

Mr. Sawday, in a well-directed critcism, disposed of this by mentioning the fact that it was impossible to tell at what time the act of fertilisation took place.

On the whole, the chromosome theory was very well received and undoubtedly gained the day.

Mr. Summerskill proposed and Mr. Toussaint second a vote of thanks to Mr. Mackenzie for his paper, and the meeting closed with a similar vote of thanks to Mr. Evans, who proved a well of information from which the meeting never drew in vain, for taking the chair and placing his knowledge so freely at the disposal of the Society.

Reviews, etc.

Hughes' Nerves of the Human Body. C. R. Whittaker, F.R.C.S.E. 2nd edition. 1918. Livingstone, Edinburgh. 3s. 6d.

This small book, which has now reached its 2nd dition, is clearly and concisely written, and should prove very useful to any student who wishes to refresh his memory on the nervous system.

All unnecessary detail is avoided, while at the same ime the essential facts are retained. The diagrams are good, although that illustrating the sympathetic and its connection to the central nervous system might be mproved. This, however, is a point of theoretical interest rather than practical importance. The general arrangement of the book and the classification of the subject into its various headings is an excellent feature of the book and shoult facilitate rapid revision.

Report of the Dentists Act Committee.

"In conclusion, we wish to state very strongly that, in our opinion, the State cannot afford to allow the health of the workers of the nation to be continuously undermined by dental neglect. Steps should be taken without delay to recognise dentistry as one of the chief, if not the chief, means for preventing ill-health, and every possible means should be employed for enlightening the public as to the need for conservative treatment of diseased teeth. The dental profession should be regarded as one of the outposts of preventive medicine, and as such encouraged and assisted by the State. Treatment should be rendered available for all needing it. The present anomalous position in which an uneducated, untrained person can practise as a dentist, performing surgical operations on the teeth and jaws, doing untold damage and casting undeserved odium and dishonour on a scientific profession is intolerable, and should be dealt with immediately."

The above quotation constitutes the final conclusion unanimously arrived at by the Departmental Committee on the Dentists Act, 1878. Such a pronouncement will be welcomed and endorsed by all who have studied the question and are interested in or concerned with the Health of the Nation. The report is exhaustive. Its findings, in so far as they relate to facts reveal a state of affairs as appalling as they are illuminating, and they confirm and emphasise, to a remarkable degree, all that the dental profession has striven so long to bring home to an ignorant and indifferent public. Its suggested remedies are radical and far-reaching, and, we believe, sound in principle.

The appointment of the Committee was due to the action of the British Dental Association, which petitioned the General Medical Council to urge the Privy Council to institute an inquiry into the extent and gravity of the evils of dental practice by persons not qualified under the Dentists Act. The request of the General Medical Council was acceded to, and the Lord President appointed a Committee in July, 1917, the personnel of which was :—The Rt. Hon. F. D. Acland, M.P. (Chairman), Mr. George P. Blizard, F.C.I.I., A.C.I.S., J.P., Mr. W. F. Bowen, Mr. W. H. Dolamore, M.R.C.S., L.R.C.P., L.D.S., Sir Almeric Fitzroy, K.C.V.O., K.C.B., The Viscount Knutsford, Sir Francis Lowe, Bart., M.P., Sir George Newman, K.C.B., M.D., F.R.C.P., Sir Arthur Newsholme, K.C.B., M.D., F.R.C.P., Mr. C. S. Tomes, F.R.S., F.R.C.S., L.D.S., Mr. F. H. O. Jerram, M.B.E. (Secretary).

It was an admittedly strong and impartial body, including a representative unregistered practitioner, and a member of the Labour Party.

The following were the terms of reference—

To investigate the extent and gravity of the evils connected with the practice of dentistry and dental surgery by persons not qualified under the Dentists Act; and to consider and report upon :—

1. The causes of the present inadequate supply of qualified dentists and dental surgeons;

2. The expediency of legislation prohibiting in the United Kingdom the practice of dentistry and dental surgery by unqualified persons; and in the event of such legislation being deemed expedient, the conditions under which certain classes of unqualified persons at present engaged in the practice of dentistry might be permitted to continue in practice, by the institution of a special Roll for the purpose.

3. The practicability, without impairing the existing guarantees for the efficient practice of dentistry of (a) modifying the course of study and examination prescribed for dental qualification; (b) reducing the time occupied; (c)

diminishing the cost of training dental students.

After hearing the evidence of a large number of expert witnesses and considering the memoranda and other documentary evidence supplied by representative bodies and societies and by persons interested in the terms of reference, the Committee duly reported on February 5th last. The report runs to some 57 pages, and we regret that our space does not permit of our giving as full a summary of its findings as they deserve and we would wish. We must be content, therefore, for the time being to reproduce some of the principal recommendations, but we hope to discuss some of the details on a future occasion.

There is one matter that strikes us as very remarkable: Tables of statistics are given, furnished by the Army Council, together with reports from various Commands, as to the deplorable dental condition of recruits. The Army Medical Authorities stand condemned out of their own mouths for their neglect in failing to provide adequate dental treatment for the troops, and the War Office for their inexplicable indifference to the value of dental surgeons and dental students as national assets, in their professional capacity, during the War.

Summary of the Principal Recommendations.

1. We are agreed that very great evils are associated with the practice of dentistry and dental surgery by persons not qualified under the Dentists Act. These evils are largely responsible for :—

(a) Lowering the social status and public esteem of the dental profession.

(b) A great shortage of registered dentists owing to the unattractiveness of the profession.

(c) Inability by the general public to distinguish between a registered and unregistered practitioner.

(d) The dental treatment of the public being largely in the hands of uneducated, untrained and unskilled persons.

(e) Grave personal injury owing to lack of skill and of technical knowledge.

2. The causes of the shortage of Registered Dentists are mainly three:—

(i.) The present unsatisfactory state of the law in allowing the practice of dentistry by unregistered persons who have not qualified for the profession by a prescribed course of instruction, training and examination.

(ii.) The present length of the minimum course of instruction and training for dental students.

(iii.) The present expense of training at a dental school.

3. With a view to providing a sufficient supply of dentists and meeting the needs of the public arising from the shortage of dentists we recommend as means which are essential for meeting present evils :—

(i.) *An alteration of the law so as to secure the prohibition of the practice of dentistry by persons not registered.*

(ii.) The registration under certain conditions of unregistered practitioners practising dentistry at the date of our report.

(iii.) A reduction in the minimum time required to be spent by dental students to acquire a qualification in dental surgery.

(iv.) The provision of dental treatment for expectant mothers and children under the age 5 years.

(v.) The completion as rapidly as practicable of an adequate system of school dental treatment.

(vi.) The establishment of a public dental service.

(vii.) The establishment of a system of scholarships for dental students with adequate maintenance grants.

(viii.) The registration after a short course of study and examination of dental mechanics employed as such during 5 years before the date of our report.

(ix.) Scholarships for dental mechanics.

(x.) Increased grants to dental schools.

4. We recommend that a special committee shall be appointed to admit unregistered practitioners, in practice at the date of our report, to registration as dentists subject to certain conditions being fulfilled.

5. A thorough research investigation into the causes and effect on health of dental caries is needed.

6. A Statutory Dental Board under the General Medical Council should be set up for the government of the dental profession. The Board shall consist of persons, including laymen, appointed by His Majesty in Council, Dentists elected by the Dental Profession, and representatives of the General Medical Council.

7. We recommend that an annual licence fee of £5 shall be paid by registered dental practitioners, to be administered by the Statutory Dental Board, and to be devoted to—

(i.) The expenses of the Statutory Dental Board.

(ii.) The provision of scholarships for dental students and during the next 10 years for dental mechanics.

(iii.) Aid to dental schools.

(iv.) Dental research.

8. We recommend that the practice of dentistry by public companies shall be subject to special control, provision being made to meet the case of existing companies.

9. We recommend that an additional column shall be added to the Dentists' Register for recording the qualification for registration of unregistered practitioners admitted to the Dentists' Register.

10. We recommend that unregistered practitioners admitted to the Dentists' Register shall use the title "dentist" or "dental practitioner," but no other title. Unregistered practitioners on admission to the dentists' register shall acquire the same legal rights, privileges, and status as are conferred by the Dentists Act, 1878, upon dentists.

In conclusion, may we express the hope that the long-suffering dental profession may be induced to sink all minor points of difference, which are sure to arise, in order that such unanimity may be arrived at as will be necessary to secure legislation giving effect to the Committee's report.

Guy's Hospital Debating Society.

The above Society was revived at a General Meeting held in the College Smoking Room on February 20th, at 4.30 p.m. Dr. Ryffel kindly consented to take the chair, owing to the unavoidable absence of Dr. Fawcett.

At the commencement of the meeting the following officials of the Society were elected:—

President: J. Fawcett, M.D.

Vice-Presidents: L. Bromley, M.Ch., F.R.C.S.; M. S. Pembrey, M.D.; J. H. Ryffel, M.A., B.Ch.; A. R. Thompson, Ch.M., F.R.C.S.; E. G. Slesinger. M.B., F.R.C.S.; T. V. Evans, M.A.

Secretary and Treasurer: C. H. C. Toussaint.

Committee: G. P. Lindsay, J. H. Burn, M. Mackenzie, B. L. Laver, A. T. Rogers, P. B. Skeels.

It was unanimously decided to hold the Annual Ladies' Night Debate before the end of the session, and in addition one ordinary meeting.

A proposal by Mr. Kirklands, seconded by Mr. Jeans, that two Sergeants-at-Arms should be elected, especially as these might be in demand on Ladies' Night, was strongly opposed by Mr. M. Mackenzie, and defeated.

The Chairman then called upon Mr. Payne to propose the motion—"That this House upholds the policy of strikes and considers them a legitimate weapon of defence,"

In a very able speech, which was all the more remarkable as he was called in at the last moment to fill a gap caused by Mr. A. Mackenzie's withdrawal, Mr. Payne outlined the history of the strike movement, starting with the over-population at the time of the industrial revolution. Owing to this overgrowth the employers possessed supreme control over their workers,

for there were always hundreds of unemployed ready to snap up any vacancies caused by dismissal. The people resented this uncertainty of their position, and thus there was a tendency for unions to form. These developed into the modern trades unions, possessing considerable power. Strikes by these unions were legitimate, because they defended the worker against attacks by their employers. The men cannot better their conditions by arbitration, because modern companies have no souls and would not consider the men's demands. Thus the only method is to strike. The masters' weapon against the men is money. No one has ever proposed to deprive the masters of their weapon, so why should the men be deprived of their weapon, the strike? If the object of strikes is the betterment of bad conditions, they are not only a righteous method but the only one to be adopted.

Mr. Kirkland in leading the opposition, stated that strikes are war, engineered by this or that faction, and it must be borne in mind that more states have been ruined by faction than have fallen before the sword of conquerors. The strikes of to-day are as much an attack on the elected leaders of labour as they are on the community. The majority of the self-appointed leaders are nothing more than Bolshevists of enemy origin, such as Læmur, Hyman & Co, who are hoodwinking the British worker, and, moreover, hold their meetings at night under circumstances which render the tired worker an easy victim to their wiles. Are we to allow production, which is now a matter of life and death both to industry and to the workpeople themselves, to be hampered by strikes brought about by foreign agitation? Don't say that strikes cannot be avoided! Deportation of aliens, enlightenment of labour, industrial councils, etc., are only a few of the methods which can prevent them. Over our heads at present there hangs the threat of an imminent national strike. Here are two facts about this strike—(1) concession to the miners' demands means absolute commercial ruin to Britain; (2) "the working miners mean well enough, but are being misinformed by agitators whose motives are not above suspicion." There is the absolute cause of strikes—the misleading of the worker by seditious alien revolutionaries. Is it common sense, by upholding strikes, to permit the fruits of hard-earned victory to be dashed to the ground. Labour is all right, left to itself. Strikes mean revolution and decay of industry. Avoidance of strikes means prosperity and commercial supremacy. Look at Russia and say, which will you have?

Mr. Lindsay, in supporting the motion, considered it an axiom that a labourer had as much right to do what he liked with his labour as the capitalist with his capital. Capital has many weapons, labour has only one—the power of ceasing to labour. He pointed to the progress already achieved by strikes in the betterment of industrial conditions. The inconvenience of a large strike was trivial compared to the gain to its promoters. Moreover, it is a wrong notion that slavery is neutralised when you are well paid for it.

Mr. Toussaint, in seconding the opposition, stated that in industry co-operation between Capital and Labour were essential. This could not be brought about by strikes, and could only be effected by means of Industrial Councils. He then outlined the formation of National Councils, as proposed by the Whitley Committee. These would be supplemented by District Councils and Workshop Committees, which would be in closest touch with the actual life in the shops. Labour, strong as it is, cannot afford to have public opinion against it, for the public is a jury to which industrial questions must be submitted for a verdict. Labour has nothing to fear more than making the public fear it.

Mr. Maizels stated that, with regard to minor inconveniences caused by strikes, we would soon have one great union of all workers, such that if the workers of one industry had the slightest cause for complaint all the industries would strike! This strike would have the desired effect, and also, as everybody in the country would be on strike, it could not last for long! If any member knew of any single instance where a strike was justifiable he must support the motion. The only people who ought not to strike are doctors and nurses, although it is agreed that the present conditions under which nurses labour are deplorable.

Mr. Mackenzie said that in the olden days the aristocracy ruled because they justified their existence in war. Now, however, the aristocracy are not fit to rule, and so the working classes are revolting. But there is another class, the middle class, composed of the intelligent and thinking people. Utopia will only be attained when the management of the country is in the hands of the thinking class.

Mr. Jeans supported the idea of Councils as being the only reasonable way of settling industrial disputes. He quoted the case of a factory where the system is already in practice, and the result has been entirely satisfactory. He also showed that the method of state subsidation of the employers, to enable them to pay higher wages, does not always succeed.

In summing up the opposition, Mr. Kirkland maintained that even Mr. Maizels' one extreme case of industrial dispute could easily be settled by an Industrial Council. At the present time the middle classes are living under miserable conditions, and yet they have not struck! Why should the working people carry matters to the extreme and strike when they can settle their disputes peacefully?

Mr. Payne strongly opposed the policy of Industrial Councils. If, on the Councils, the employers and workpeople cannot agree, they come to a deadlock, and the only thing left to the workers is to strike.

The Chairman then put the motion to the vote, whereupon it was carried by 16 votes to 9. The meeting concluded with a hearty vote of thanks to Dr. Ryffel for taking the chair. There were 38 members present.

Scabies and Pediculosis Corporis.

(*Continued.*)

By H. W. BARBER.

Pediculosis Corporis.

It is a noteworthy fact that in civilian practice the three species of louse which infest human beings seem to show an individual predilection according to the age of the host. Thus, the pediculus capitis is found chiefly among children and young girls, the pediculus pubis in adult life, perhaps because it is usually transmitted by sexual intercourse, and the pediculus corporis among old persons. In the army, of course, it was the body louse which proved the chief offender, attaining, indeed, such prevalence that in front areas practically everyone became infected at some time or other. Peacock (B.M.J., May 27th, 1916) found lice upon 95 per cent. of the soldiers who had been at the front in the British army for six months or more. In the shirt of one man he found over ten thousand lice and ten thousand eggs! He showed that the men themselves and their personal clothing were the chief agents in the spread of infection, but he found, as a rule, comparatively few lice in blankets; nevertheless I have myself been infected from blankets on at least three occasions. Infection from lice, living away from a host in dug-outs and trenches, probably rarely occurred.

Among soldiers the pediculus capitis was uncommon, and the pediculus pubis was relatively seldom seen. I have seen two men on whom all three varieties flourished, and they were both mentally defective. One man, on whom pediculi pubis were found in great numbers, afforded me the most beautiful example of "taches bleues" that I have ever seen.

It is not proposed in this article to deal in detail with the habits and life-history of the body-louse, nor with the various methods which were employed in the army in the attempt to cope with its spread. Those interested in the question should refer to the writings of Bacot and Peacock (B.M.J., January 29th and September 30th, 1916). Suffice it to say that preventive measures were singularly unsuccessful, and, bearing in mind that, apart from trench fever, practically all cases of so-called "boils" and "impetigo," which were not associated with scabies or primary seborrhœic eczema, were the result of lousiness—a fact which was by no means generally admitted—the enormous amount of disability for which this parasite was responsible may readily be imagined.

Out of 631 cases of pyodermia, studied by Semon and myself during a period of one month in France, 452 were associated with parasitic infection (71·6 per cent.); of these, 171 (37·6 per cent.) were consequent upon scabies alone; 257 (56·9 per cent.) were secondary to pediculosis; and in 24 cases (5·5 per cent.) the two infections were co-incident. Nearly all the remaining patients were suffering from impetiginised seborrhœic eczema.

The pediculus corporis is larger than the head-louse, measuring nearly 3 mm. in length, and the females are larger than the males. The parasites shelter in the seams of the underclothing, but may be found wandering in the pubic or axillary hair, and sometimes may be discovered in the act of feeding. They are very prolific, and, according to Leuwenhœck, two pregnant females can in two months give birth to 18,000 young! But, according to Bacot, the average longevity of adult lice is only thirty-four days, during which time a female will lay about six eggs per diem, and, if kept away from the human body, they die in nine or ten days.

The eggs or "nits" have a chitinous covering, and are attached (1) to the fibres of the material of undergarments, particularly along the seams; (2) *to the hair of the pubis, axillæ, chest, or perineum.* Before the war it was not generally recognised that the body-louse may attach its eggs to the hair of the body, and Semon deserves great credit for observing how frequently this occurred among soldiers. I was able to prove the truth of his assertion by hatching out young pediculi corporis from egg-laden pubic hair, kept warm in the small side-pocket of my tunic. Moreover, it is quite easy for the experienced eye to distinguish at a glance between the eggs of pediculi corporis and those of pediculi pubis, fo the latter are very small, usually dark in colour, and are *attached near the base of the hair*, whereas the former are larger, of a greyish colour (almost white when the young are hatched), and are *attached to the more distal parts of the hair.*

In soldiers badly infested with body-lice, the pubic hairs, and to a less extent those of the axillæ and perineum, were often found to be laden with eggs, and adult females and newly-hatched young were frequently seen crawling amongst them. It will, therefore, be understood that a bath and a change of clothing were not sufficient to render a man free from lice, since, unless the eggs on the hair of the body were simultaneously destroyed, young lice would shortly hatch out and reinfect the clean clothing. Semon and I found that in cases of pediculosis, in which new lesions developed while the patient was actually under treatment in hospital, careful search of the hairy regions almost invariably revealed the presence of "nits," which had escaped the attention of the orderly in charge, whereas fresh lesions practically never appeared if care was taken to "sterilise" the hairy parts, as well as to provide clean clothing.

In clothing that is worn night and day the eggs hatch in from seven to twelve days, but if the clothing is discarded for several hours each day the length of time may be prolonged to three or four weeks; the incubation time, therefore, depends on the temperature at which the eggs are kept. But "nits" may remain dormant in clothing away from the body for many weeks. The young lice are but miniatures of their parents, and undergo no metamorphosis during their development.

The Lesions of Pediculosis corporis.—The early lesion produced by louse-bites in a person unaccustomed to their presence is probably almost always of an urticarial nature, but this urticarial reaction tends to disappear, if lice be harboured for any length of time. Urticaria was hardly ever seen in chronic cases of pediculosis among troops in France, and it is probable that the poison injected by the louse when feeding, which causes the urticaria, becomes in time neutralised by some antibody elaborated by the host, for not only is no local reaction produced by a bite in chronic cases, but the itching may also diminish or completely disappear.

(To be concluded.)

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *in any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Mr. Editor,—I was much interested to read in "Passim," in the last number of the Gazette, the article referring to the suitability of an Hostel at Honor Oak Park as a War Memorial. I was interested inasmuch as a few months previous to the outbreak of war I had commenced to draw up a similar scheme, the outcome of a suggestion to me by Sir Cooper Perry. A large influx of Dental Students had taken place at that time,

and accommodation in the College and neighbouring lodgings was difficult to obtain. To find out whether such a scheme found favour with the students, I interrogated all the junior men in the Dental Department, about seventy in all. Of these about half lived at their homes, and of the other half all were greatly in favour of such an institution.

There are hostels associated with other educational institutions, *e.g.*, University College, and although building materials and labour have increased much in cost, such a scheme should be feasible for Guy's. Ingram House, at Stockwell, also is an hostel of a similar nature, and has been patronised by more than one Guy's student, and certainly by students from other hospitals.

As to whether such a scheme is suitable as a War Memorial, I have not the slightest hesitation in giving an affirmative answer. For one thing it would be a memorial of a concrete type, and as such would appeal more to the sentimental side of one's nature, as all memorials worthy of the name should do, than a memorial of a more abstract kind. Further, and this is not without rather pathetic interest, about twenty per cent. of the men I interrogated, and who were greatly in favour of such a scheme, are to be numbered as members of that gallant company whose memory we so desire to perpetuate. I have little doubt in thinking that if their silent lips could but speak, they would utter the wish that their memory might be kept green by the erection of an edifice, which found such favour with them, for the better and healthier living of future generations of Guy's students.

I am, dear Mr. Editor,
Yours faithfully,
F. BOCQUET BULL.

24, St. Thomas' Street,
London Bridge, S.E. 1.
March 3rd, 1919.

DEAR SIR,—On reading through the "Passim" of your last issue, I was greatly impressed by your suggestion that the Hospital War Memorial should take the form of a College, somewhere in the vicinity of Honor Oak Park. The present College is both unhealthy and expensive, and the fact that it is so far from the Athletic Ground only adds to its disadvantages.

I think that, provided such an establishment could be run on a much more economical basis than the present one, it would not lack patrons.

There is not the least doubt that it would be a fitting memorial, but more detail would be needed before putting such suggestions to the vote. Would it not be possible to make a rough estimate of the cost of living in such an establishment? We should like to hear more about this idea.

Yours, DISSECTOR.

DEAR SIR,—The Editorial of the GAZETTE have from time to time asked for suggestions in regard to the Guy's War Memorial. Rather than offer any fresh suggestion I should like to lend my support to the scheme adumbrated in the last issue, viz., the erection of a Residential College near the Athletic Ground at Honor Oak Park.

I was present at the dedication service in the Colonnade many years ago, of the Guy's South African War Memorial.

This Mural Fountain, although a symbol which must command respect and reverence on account of that which it commemorates, yet always appears to me a poor tribute to those gallant Guy's men, serving rather as a centre piece to the notice boards on either side!

So I would urge that the Memorial of the present war should take some more useful form—as a Residential Establishment, which may be of lasting benefit to Guy's men of this and future generations, where students may have the opportunity of living in healthier and more sanitary conditions than the existing College affords, and where, in the earlier years at any rate, they may have access to the open space of the Athletic Ground for daily outdoor exercise and breathing purer air.—Believe me, yours faithfully,

A. ALAN FORTY
(President of the Residents).

Guy's Hospital,
London, S.E. 1.
March 3rd, 1919.

DEAR SIR,—In your last issue you have voiced a real complaint, but better still have propounded an admirable solution. A College or Hostel at Honor Oak Park is the very thing that is required.

You have given good reasons why such a step is desirable, but let me add another: Under the existing circumstances it is impossible for men to get to know one another apart from work. The only place where all meet is in the College dining room, where, of course, men feed with their own set. Should an unfortunate junior man find himself seated at a table of senior men he feels like a miserable worm, and not like a student of the same hospital as his seniors.

A hostel at Honor Oak Park, where the junior men could live, and seniors, whose ward appointments did not necessitate their living in, could reside, would go far to remove this. At such an institution men would meet in a common room, at sport, and in going to and from sport. It would go far to remove the loneliness of some students who have no relatives and friends in London, and it would direct their leisure hours in the right direction.

A college so founded would indeed be a fitting memorial to "perpetuate for ever the willing services and sacrifice of Guy's men in the war." To bring home to everybody the object which such a hostel was built to commemorate, it could be known as "The Memorial College," or "The Memorial Hostel."

I am, yours sincerely,
SIMPLE SIMON.

The College,
3rd March, 1919.

Football.

ASSOCIATION.

GUY'S v. ST. OLAVE'S GRAMMAR SCHOOL.

Played at Honor Oak Park on Feb. 8th. Guy's kicked off on a very hard frozen ground, rushed the ball down the field, and scored in the first minute of the game. The opposing forwards were very clever and were soon bombarding our goal, but our defence kept them out well till Bryant rushed through on his own and scored. The ball was very light, and the forwards on both sides had the advantage over the defence. At half-time the score was 5–3 in their favour. Play was very fast in the second half. Guy's opened the scoring and St. Olave's immediately replied. Later our forwards playing with more dash, scored two in quick succession, thus drawing level. Both sides now worked hard for the winning goal. It was soon evident that the School were in better training than our men, and before the end Bryant, their centre forward, again scored. Thus we lost a very even contest by 6 goals to 7.

Team.—W. G. Hore (goal): E. F. Hewlitt, E. Bernstein (backs); R. J. Cann, J. B. Gregor, E. R. Webb (halves); D. J. S. Thomas, W. G. Booth, G. P. Lindsay, P. Sedgewick, L. W. Cann.

GUY'S v. ST. OLAVE'S GRAMMAR SCHOOL.

Played at Honor Oak Park on Feb. 15th. We looked forward with some keenness to this return match, and were not disappointed in the result, which was a win for us by 4 goals to 3, though our boastings cease when we remember that our opponents unfortunately had only ten men throughout the game. The ground conditions were exactly reversed, being muddy and slippery after the thaw, and several changes were made in our team.

St. Olave's were the first to score after a very pretty combining movement by their forwards. Our forwards could not settle down, and the defence were hard pressed before they could get their second wind, until one of them miskicked badly, which let their centre forward in to score again. Guy's now played up better, and after an exciting scrimmage in front of their goal we managed to get the ball into the net. Before half-time they scored again. In the second half the fact of our opponents being one man short just made the difference, and our forwards had more of the ball. There were several exciting moments for both sides when the score stood at 3 all, and until ten minutes before time the result was uncertain, when their outside right was hurt and had to go off. After this Guy's had it all their own way, but could only score once. Gregor played a capital game at right back.

Team.—W. G. Hore (goal); J. B. Gregor, F. J. Smith (backs); S. V. Strong, L. W. Cann R. J. Cann (halves); H. N, Schapiro, —. Jones, G. P. Lindsay, W. A. Caldwell, D. J. S. Thomas.

GUY'S v. KING'S COLLEGE.

February 19th.

Scratched on account of the state of the ground.

GUY'S v. OLD CITIZENS.

February 22nd.

Scratched on account of the state of the ground.

GUY'S v. St. JOHN'S SCHOOL.

February 26th.

Played at Leatherhead.

Considering the quantities of rain, the condition of the ground was good. The Hospital team was not at full strength, but even so it is hard to account for the lamentable display that was put up in this match, which resulted in a defeat by 7 goals to nil.

From the very outset the cheering of the boys—who turned out in full strength to witness this last school soccer game, seemed to paralyse our efforts, and the resulting play was a series of mis-kicks and bad passes on our part, which beggars description.

Hore played an excellent game in goal and made many fine saves, but for the rest it was an off-day.

Team.—W. G. Hore (goal); E. R. Webb, E. F. Hewlitt (backs); S. V. Strong, R. J. Cann, L. Bannounah (halves), P. Sedgwick, W. G. Booth, G. P. Lindsay, W. A. Caldwell, S. V. Thomas (forwards).

GUY'S v. BART.'S.

This game was played at Honor Oak Park on March 1st, and resulted in a win for Guy's by 4 goals to 3. Bart.'s won the toss and decided to kick against the wind. The ground was very sticky, and for a time neither side could control the light ball. The Bart.'s forwards frequently got the ball, but never looked dangerous. Presently a mis-kick by one of their backs let Caldwell in, who scored easily. Guy's now played better. O'Meara at centre half gave his forwards plenty of chances, one of which they took and scored again. Bart.'s now pressed hard, but Hore kept them out well until just before half-time, when he was beaten at close range.

In the second half the strong cross wind kept carrying the light ball into touch, but the Guy's halves controlled it well and enabled their forwards to score 2 more goals. With the score at 4—1 against them Bart.'s made tremendous efforts and for a time carried all before them, scoring 2 goals in quick succession. They tried hard to equalise, but our defence was sound, and near the end we almost scored a fifth, Booth hitting the cross-bar with a good long shot. The whistle blew with no further score.

Team.—W. G, Hore (goal); E. F. Hewlitt, J. B. Gregor (backs); H. A. H. Harris, P. J. O'Meara, R. J. Cann (halves); L. W. Cann, W. G. Booth, G. P. Lindsay, W. A. Caldwell, S. J. V. Thomas (forwards). Referee W. Harris.

RUGBY.

GUY'S "A" v. R.M.A., WOOLWICH.

This match was played on the 22nd February at Woolwich. Rain fell almost continuously throughout the match, and the heavy ground rendered open play difficult. Nevertheless, Guy's soon got well away and scored three tries in quick succession. The first was scored by Jones after a pass from Krige. It was placed near the corner and was not converted. Forward play, however, soon brought the ball back to the line, and Shelswell was enabled to score. Jones narrowly failed to convert. The third try was scored by Krige who made a fine swerving run down the field, eluding with marvellous skill the several opponents that tried to tackle him. This try was converted by Jones. After this the play was much more even, neither side scoring until very near half-time, when a run by the three-quarters left Greenway in possession of the ball, and he got through to score the fourth try. The kick failed, so that Guy's led by 14 points to nil at half-time.

Despite this formidable lead, the "Shop" was undaunted and played up wonderfully well when the game was resumed. Indeed, it was they that had the major part of the play during the second half. During this half they scored two unconverted tries, whilst just on time Laver scored for Guy's. His try was not converted

Considering the state of the ground the game was a very good one, but the team must remember that when a decisive lead is obtained, this must not produce slackness. Result: Guy's 17 points; R.M.A., 6 points.

Guy's "A"—Back: T. A. Shaw; three-quarters: H. B. Jones, P. Krige, E. C. Seward, C. W. Greenway; halves: N. L. Lloyd, S. P. Meacock; forwards: A. H. Shelswell, L. K. Watson, B. L. Laver, P. J. Morrison, J. A. Currie, J. J. du Toit, —. Hutchinson, J. Goodenough.

GUY'S v. OXFORD UNIVERSITY.

Played at Oxford on February 26th. For this game the Hospital were not at full strength, the absentees including Doherty, Marais, Woodroffe and Day-Lewis. The two teams were very evenly matched however, and the University gained a narrow victory by nine points to six. The weather conditions were ideal and the ground in excellent condition.

A fine opening by Shand early in the first half led to Oxford scoring an unconverted try; from now until the interval the game was very closely contested and there was no further scoring.

On resuming, the Dark Blues were again prominent, and following some play in the Guy's "25," scored another try. The place-kick failed.

The Hospital now began to make greater efforts and tries were scored in rapid succession by Krige and Crook, neither of which was improved upon. A draw now seemed inevitable, but Oxford pressed strongly towards the end of the game, and securing the ball from a line-out, just by the line, one of their outsides went over with another try; this was not converted, and the University were left winners of a fast, bright game, by three tries (9 points) to two tries (6 points).

The tackling in this game was not quite up to the average, and a little more combination among the forwards might have led to a win for the Hospital; on more than one occasion the Guy's scrum consisted of five men who could not be expected to be equal to their opponents' eight: individually, the forwards were all good, and Bekker was prominent among the backs.

Team.—T. A. Shaw (back); Greenway, P. Krige, E. C. Seward and H. P. Jones (three-quasters); W. H. Cellier and F. Bekker (halves); F. W. Reitz, A. H. Shelswell, F. W. Crook, L. K. Watson, B. L. Laver, P. J. Morrison, J. A. Currie and Hutchinson (forwards).

Roll of Honour.

Dead.

Major H. G. Gibson, R.A.M.C.

Capt. J. S. Cocks, R.A.M.C.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contribution to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Birth.

MUNDEN.—On the 23rd February, at Ilminster, Somerset, the wife of W. P. Henley Munden, M.D., of a son.

Marriage.

PRICE HARRIS—TWEMLOW-COOKE.—On March 4th, at Parish Church, Sidmouth, Major L. Price Harris, M.C., R.A.M.C.(T.), younger son of Mr. and Mrs. E. W. Price Harris, of Woking, to Amy Victoria Mary, only daughter of the late Rev. D. J. Twemlow-Cooke, M.A. Cantab., and Mrs. Twemlow-Cooke, of Sidmouth.

G. B. D.
G. P. L.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 801.] MARCH 22, 1919. [SIXPENCE.

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Passim.

THE question of the form of the Guy's War Memorial has been carried into the other camp by Mr. T. B. Layton whose admirable letter we publish on another page. With the exception of a simple tablet bearing the names of the fallen, Mr. Layton is entirely opposed to devoting this fund to anything except financial aid either to dependents of the fallen or to those connected with the Hospital who are in "financial difficulties as a result of the war." His scheme which is very clearly set out in the "Memorandum on the War Memorial Fund" following the letter, corresponds closely with that contained in the appeal which appeared in our War Memorial Number. The plan of devoting the main part of the Fund to "financial assistance" was evidently the one which commended itself most strongly to those who drew up that appeal, namely, the widely representative War Memorial Committee.

It is not our intention to take up the cudgels on behalf of the War Memorial Hostel. That proposal, which we feel sure will find further support in our correspondence columns, was the outcome of a feeling that the Guy's War Memorial should be something more permanent and concrete than scholarships, and that "financial assistance" was more the obligation of the State. There will be many who would like to see their Hospital enriched by some new building, beautiful in structure, yet not without some utilitarian purpose. This would be on the same lines as some of our Public Schools are proposing to erect to commemorate their fallen. It would scarcely benefit the present generation of students, but rather their successors, to whom it would be a constant encouragement and inspiration for ever. At the same time all who can recall to mind such a tragic scene as Mr. Layton has depicted will find a very strong appeal in his words that the first consideration should be the dependents of our imperishable Dead.

A MEETING of the Inter-Hospital Cricket Club took place on March 18th. Representatives from all the big London hospitals were present, and Dr. Calvert was in the chair. It was unanimously decided to re-open the inter-hospital competition for the challenge cup this year. In the first round Guy's have drawn Bart.'s. We feel sure that the Guy's C. C. will spare no effort to retain the cup.

WE understand that several books borrowed from the Wills Library have not been returned. The Librarian, whom we welcome back again,

was amazed to find that certain books were long overdue—one or two even since 1914. This laxity is probably due to war emergency, but it is of the greatest importance that these books should be returned to the Librarian without delay.

We regret to hear that Mr. E. W. H. Shenton has resigned his appointment in the Radiographic Department. Mr. Shenton has received special mention for work in connection with the war, and we understand his resignation is due to pressure of military work in other X-ray departments.

We congratulate Mr. F. N. Doubleday, L.R.C.P., M.R.C.S., L.D.S., on his appointment to be Assistant Dental Surgeon to Guy's Hospital.

The letter we publish below, which has been received from the Board of Education, contains a fact which is not generally known, and one which may be of great use to certain of our readers. It will be noticed that it is not necessary for the applicant to have actually passed the First Professional or Preliminary Science Examination.

[Copy.] Board of Education,
Whitehall, London, S.W. 1.

Higher Education of Ex-Service Medical and Dental Students.

Sir,

I am directed to refer to the Board's letter of the 7th February last, which stated that, as far as interim grants were concerned, applications on behalf of medical students should be limited to those who had already passed, or were sufficiently advanced in their studies to enter for, the Intermediate Examination for a Degree in Medicine.

The Board has now decided that, subject to the condition that the student cannot continue his course without immediate financial assistance, they will be prepared to consider applications for interim grant on behalf of those Medical and Dental Ex-Service Students who have already passed their first professional or preliminary science examination for a medical or dental qualification, or who will enter for this examination on the next occasion on which it is held.

I am to ask the authorities to inform the Board as soon as possible which of the students on whose behalf they have already applied for interim grant satisfy this condition.

I am, Sir,
Your obedient Servant,
(Signed) L. A. Selby-Bigge.

We regret that we have been forced to hold over the conclusion of Dr. Barber's article on "Scabies and Pediculosis Corporis," until our next issue.

Guy's Hospital War Memorial Fund.

	£	s.	d.
Brought forward	2,686	13	2
Latimer, H. A.	1	1	0
*a*Watkins, J. P.	1	1	0
Peters, E. A.	2	2	0
Marshall, W. L. W.	2	2	0
Gillingham, A.	1	1	0
Hardy, H. M.	1	1	0
White, Miss G. L.	2	2	0
Domville, E.	1	1	0
Lockyer, G. E.	5	5	0
Hope, W. B.	1	1	0
Miller, W. H.	5	5	0
Jackson, T. S.	2	2	0
Manser, F.	5	5	0
Lansdown, R. P.	5	5	0
Penrose, A. W.	5	0	0
Hamilton, G.	2	2	0
Harris, Robert	5	5	0
Sandoe, J. W.	10	10	0
Pollock, J. R. R.	2	2	0
Henderson, R. W.	1	1	0
Grellet, H. R.	1	1	0
Webb, H.	3	3	0
Jones, C. E. M.	1	1	0
Hicks, C. E.	2	2	0
*a*Hawkins, C. F.	1	1	0
Payne, O. V.	5	5	0
Munden, Charles	1	1	0
*a*Scott, E. D.	1	1	0
Moyle, H. H.	1	10	0
Kirkman, A. H. B.	1	1	0
Wallis, F. R.	2	2	0
Porter, A. E.	1	1	0
Gould, H.	1	1	0
Wright, H. H.	5	5	0
Paradise, T. D.	2	2	0
Foster Smith, G. T.	1	1	0

	£	s.	d.
Churchill, Brooke	5	0	0
Hampton, F. A.	5	0	0
*b*Robinson, J. F.	1	1	0
Sturges-Jones, W. E.	1	1	0
Pryn, W. W.	5	5	0
Perkins, H. B.	5	5	0
Galbraith, D. H. A.	5	5	0
Watson, C. E. S, ...	5	5	0
Lowdell, S. P.	1	0	0
Curle, R. and Mrs.	2	2	0
Hancock, A. C.	2	2	0
Coffin, S. W.	1	1	0
Parrett, E. E.	5	5	0
Pedley, C. F.	2	0	0
Dean, C.	5	5	0
Reinhold, C. H.	5	0	0
Brogden, R. W.	21	0	0
Brogden, Mrs. C. M.	21	0	0
Brogden, Miss H.	1	1	0
Brogden, Miss M.	1	1	0
Allan, D.	2	2	0
Hedden, Richard	1	1	0
Prentis, J. E....	2	2	0
Fawcus, R. A.	2	2	0
Wilkinson, H. B.	5	5	0
Garner, W. L.	2	2	0
Bramley Taylor, W.	2	2	0
Jackson, J. L.	5	5	0
Annesley, F. D.	3	3	0
Clewer, D.	2	2	0
Watson, J. N.	1	1	0
*c*Fry, L. S.	5	5	0
Gatley, C. A. R.	5	5	0
Johnson, W.	10	10	0
Hewetson. H.	10	0	0
Bromley, L.	25	0	0
Marriott. H. B.	5	5	0
Lowry, T. Martin	10	0	0
Andrews, E. G.	1	1	0
Sheldon, Miss A.	2	2	0
Gripper, G. D.	2	2	0
Sutcliffe, Mrs. E. M.	2	2	0
Pinching, W. G.	3	3	0
Jones, John H.	2	2	0
Turner, Thos.	5	5	0
*d*Wood, T. Nevill	5	0	0
Cook, I. R.	2	2	0
Walker, J.	5	5	0
Harkness, A. H.	5	5	0
Pollard, J. McFarlane	2	2	0
Tustian, T. B.	1	1	0
Loud, Frank	2	2	0
Pye-Smith, R. J.	2	2	0
Martin, J. B.	2	2	0
Hudson, A. B.	2	2	0
Traill, R. R.	10	0	0
Carden, W. A.	10	10	0
Chubb, W. L.	2	2	0
Payne, A. Ll. Spencer	2	2	0
Messrs. S. Floyd and F. B. Lowe ...	10	10	0
*e*Eyre, J. W. H.	20	0	0
*f*Thorne, J. M.	5	5	0
Wood, W. R.	5	5	0
Berry, H. Poole	2	2	0
Woodhouse, A. E. Clayton	5	0	0
Hutchinson, F. E.	2	2	0
Pendred, Vaughan	2	2	0
Covell, G.	5	0	0
Doubleday, F. N.	10	10	0
Tilbury, R. ("In memory of Arthur Tilbury and John A. Edmond")	10	0	0
Mayer, C. A L.	5	5	0
Birdwood, G. T.	10	0	0
Total	£3,147	16	2

a First annual instalment of total contribution of £5 5s. 0d.

b Similar sum to be contributed next year.

c On account of total contribution of £20.

d On account of total contribution of £10.

e Further instalment towards total contribution of £50.

f On account of total contribution of £10 10s. 0d.

Change of Address.

W. S. Kidd, M.B., B.S., late Temp. Surg.-Lieut. R.N., from Royal Marine Garrison, Stromness, Orkney, to 22, York Place, Harrogate.

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Major G. T. Willan, D.S.O., R.A.M.C.(T.F.), from 82nd Field Ambulance, Salonika Force, to 302 Field Ambulance, Ipswich.

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Capt. S. W. Coffin, R.A.M.C., c/o H. L. Coffin, Esq., Southside, Meadway Close. Golders Green, London, N.W. 4.

Capt. H. F. Stephens, R.A.M.C., from M.O. i/c D.A.C., R.F.A., to O.C. 14 Motor Ambulance Convoy, B.E.F.. France.

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Capt. L. D. Wright, *Ibid.*

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Mr. T. B. Layton, from 87, General Hospital, Alexandria, E.E.F., to 10, Welbeck Street, W. 1.

Sir W. Arbuthnot Lane, Bart.

By the promotion of Sir Arbuthnot Lane to the Consulting Staff of the Hospital, Guy's loses the active services of a surgeon who has made the name both of his hospital and of himself justly famous throughout the surgical world. His writings have been both varied and numerous, and whatever subject of anatomy or surgery he has dealt with has been clarified by the peculiarly unfettered and original mind with which he has approached it. Not only has Sir Arbuthnot advanced the technique and methods of operation in numerous fields, but he has also contributed largely to the elucidation of many general problems of anatomy, pathology and surgery, some of his views having passed into the realms of accepted text-book fact, and others being still the centre of very considerable controversy.

It is impossible in the present place to review in detail the whole of his many-sided work, but it may, perhaps, serve to illustrate how extensive that work has been by noting briefly the more important of his publications.

Among the earliest subjects on which Sir Arbuthnot wrote was the treatment of empyema in children by the removal of a portion of a rib,[1] a surgical commonplace of to-day which excited considerable controversy at the time of its publication; and his subsequent interest in fractures is foreshadowed in a series of papers published in 1883—85 and dealing in particular with fractures of the hyoid bone and of the sternum,[2] and with certain ununited fractures of the long bones. In 1885 he began a series of studies into the changes which pressure and tension can bring about in the human skeleton,[3] and followed these with detailed investigation into the particular changes which occur as the result of specialised life-long occupations such as that of charwoman, shoemaker, etc.[4] The results so obtained he utilised to propound a mechanical and static theory of the causation of such deformities as flat-foot, lateral curvature, knock-knee, etc.,[5] and of such diseases as rheumatoid arthritis, osteitis deformans, etc.,[6] and it is interesting to note how these early anatomical studies form the basis upon which the greater part of his subsequent work on the surgery both of fractures and of chronic intestinal stasis is based. In 1888 he published some important and original observations on the differences in form of the male and female pelvis, and their causation,[7] and in the following years wrote on a variety of surgical subjects, including some particularly striking papers on mastoid disease and lateral sinus thrombosis and its treatment by ligature of the jugular vein in the neck,[8] an operation which, we believe, he was the first to perform. During this period he also contributed largely to the treatment of paraplegia in Potts' disease by laminectomy,[9] and advocated the introduction of saline solution into the circulation for the treatment of severe hæmorrhage.[10]

In 1892 he described new operations for dorsal dislocation of the femur, for nephrorrhaphy, and a modification of the then usual operation for excision of the tongue [11, 12, 13], and in the same year wrote an interesting article on "the fallacy of the vertical foot-piece," an opinion the truth of which has been many times rediscovered during the present war.[14] In 1893—4 Sir Arbuthnot suggested and described the uses of sulphur in surgery,[15] and began the long series of papers on the treatment of fractures which have done so much to advance the surgery of this important subject.[16] In this period he also worked on the subject of periurethral abscess, the pathology of which he was the first to describe in its modern form.[17]

From 1894—9 his writings were mainly concerned with the operative treatment of frac-

tures, first by means of wires and screws, and later by the use of his own bone plates which are now so generally employed. In 1897 appeared also his first important contribution on the subject of cleft palate,[17, 18] a question which he made peculiarly his own. From this period until 1902 he was mainly interested in the operative treatment of simple, ununited and malunited fractures, and in this year also published a very valuable article on the uses of respiratory exercises in the nasopharyngeal lesions of childhood,[19] and a revolutionary description of an operation for cleft palate in a child aged $2\frac{1}{2}$ days.[20]

The activity of Sir Arbuthnot Lane's surgical imagination is well illustrated by a letter he wrote in this year on the subject of "surgical operation in mitral stenosis."[21] In 1903 he described the anatomy and causation of those fractures of the ankle previously classified together as Potts' fracture,[22] and in this and the following year began his work on chronic intestinal stasis round which such extensive discussion has ranged.[23] This subject, and Lane's views as to its pathology, symptomatology, and treatment are too well known by Guy's men everywhere to need any detailed discussion here ,but it must at any rate be recorded that his original papers on the state of the abdomen in this condition, describe in detail the various bands and membranes which have since had the names of the authors of considerably later descriptions attached to them, as, for example, in the case of the so-called Jackson's membrane.

In 1905—09 various more comprehensive descriptions of the condition of chronic intestinal stasis appeared, and in the latter year a description of congenital dilatation of the colon and its treatment.[24] In 1908 appeared several instructive papers on the subject of cancer of the rectum, containing both improvements in technique and the results of operation,[25] and from that period until now his interests have mainly centred round the further development of his theories in regard to chronic intestinal stasis and in the operative treatment of fractures.[26]

Sir Arbuthnot Lane's activities have covered such a wide field of surgery that any review of his work can at best be but a bald record, and many of his contributions have been sufficiently revolutionary in character to require the balance of time before their weight can be fully estimated. His mind has always thrown new light upon any subject in which he has become interested, and his ingenuity and originality are well instanced by the deftness of his manipulation in his fracture operations and the mechanical perfection of the ingenious instruments he has devised to help him. Although Sir Arbuthnot's mind is not of the type which excels in teaching of a systematic kind, yet his restless energy and his intense keenness and personality have always exercised a profoundly stimulating effect upon those who have been fortunate enough to work with him, and his universal kindness, interest and charm will make his absence from the hospital keenly felt and regretted for many a day.

Guy's men are justly proud of his achievements and wish him many years of continued activity in which to add further to an already renowned and illustrious career.

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THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contribution to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Honours.

O.B.E.

Capt. F. T. H. Wood, M.D., B.S., B.Sc., R.A.M.C.

Bar to Military Cross.

Capt. H. L. Messenger, M.C., R.A.M.C. For conspicuous gallantry and devotion to duty on Sept. 15th, 1918, near Doldejali. He led a party of stretcher bearers some 400 yards across the open, through a heavy barrage, and succeeded in rescuing and bringing in a large number of casualties to his advance post. Next day he established touch forward with the attacking battalion, under heavy artillery and machine-gun fire. Throughout the action he showed the greatest energy and disregard for personal danger.

Military Cross.

Capt. (Acting Major) A. L. Shearwood, R.A.M.C.

Distinguished Service Cross.

Prob. Sub-Lieut. A. A. Osman, R.N.

Mentioned in Despatches.

For services rendered in Palestine, Capt. (Acting Major) G. B. Pritchard.

The names of the following Medical Officers are mentioned for distinguished and gallant services and devotion to duty in a despatch from the Commander-in-Chief of the Mesopotamia Expeditionary Force :—

R.A.M.C.

Major T. J. Wright, D.S.O.; Capt. J. M. H. Campbell.

I.M.S.

Capt. C. M. Plumptre.

Civil Medical Practitioners' War Services.

Under date March 4th, the War Office has issued the following list of Civil Medical Practitioners whose names have been brought to the notice of the Secretary of State for War for valuable medical services rendered in the United Kingdom in connection with the war:—H. Bentley, H. W. Bethell, J. Black-Milne, J. C. O. Bradbury, E. H. Brock, W. F. R. Burgess, A. J. Carter, W. L. Chubb, P. P. Cole, H. P. Costobadie, E. Farr, F. W. Fawsett, G. W. B. Featherstone, P. Furnivall. B. Glendinning, E. C. Greenwood, D. W. C. Hood, R. D. Mothersole, J. I. Palmer, G. H. Pennell, T. B. Poole, G. L. Preston, R. M. H. Randell, E. F. Reeve, H. T. Sells, O. B. Shelswell, E. W. H. Shenton, H. J. Spon, N. F. Ticehurst.

Fear—the Major Emotion of War.

Paper read before the Guy's Physiological Society by R. J. HODGKINSON.

This is a subject in which everyone has his own facts and data; it is not necessary to rely on abstruse and lengthy experiments performed by other people, the usual second-hand and "part-worn" knowledge.

I suppose everyone has felt fear; anyhow there has been a unique opportunity in the last four years or so for experiencing it. Perhaps some who have felt fear, especially on active service, are not inclined to admit it—soldiers should not be afraid! I hold that fear is natural and nothing to be ashamed of; I say fear, mark you, *not* flight. So that it remains to be seen if my remarks coincide with ordinary experience.

Now the outward appearances of fear—the cheap novelette gives them, and so does Charles Darwin. The heart beats quickly and violently palpitates and knocks against the ribs; the whole body trembles, especially the muscles of the lips and limbs; the knees knock together; eyes and mouth are open wide; the pupils of the eye dilate; the face is pale, and so great may be the vaso-constriction that an almost blue cyanosed appearance has given us the phrase "to be in a blue funk"; there is hard and rapid respiration, almost breathlessness; the hair may stand erect; sweat pours out, "cold sweat," popularly called; the mouth is dry and parched; and so on.

This brief account can hardly fail to depict the frightened man; at the same time it might be taken for the description of the hunted man or animal in the act of fleeing from impending danger—the trembling limbs, rapid heart beat, the parched mouth—the very accompaniments of the hard muscular effort of flight. In fact, it may be summed up as "going through the motions," as they say in the army, of flight without the motor action; the analogy is complete up to the very sweating, which is of necessity cold.

Self-preservation is *the* fundamental instinct innate in every living thing and creature. *As* it is the most primitive, *so* it is the most potent, and is always with us. It can be summed up in the animal world as the motor act of *fight* or *flight*.

"In ye ancient days" our ancestors expected to meet a lion or dragon round behind the next bush. The prehistoric man fought, or escaped by running or was eaten—the daily round must have been more than exciting to say the least of it; so he devised caves and walled cities, where he could live in peace. He made him weapons—spears, bows and arrows; he no longer went in constant danger though the perils were there just the same. Having his walled city and his sharp spear the need for flight was often unnecessary; he did not always run when he met our hypothetical lion, though prompted to by his experiences and those inherited from his forefathers—he *felt* fear. The appearance of lions had created what may be called a "brain-pattern." Whenever the "lion" stimulus was given, the same responses, the agony of flight and escape, were automatically prompted, though, as I say, the motor action does not always take place. He experienced what we know as emotion—the emotion of fear. Crile puts it in a few words: "The stimulation of the mechanism leading to a physical struggle is motor action; and the stimulation of the mechanism without motor action is emotion—fear is phylogenetic flight."

Now, Nature was not idle in the primitive struggle. Before man could evolve his own defences, nature had built up a most efficient and powerful protective mechanism for him—a series of internal processes which became active the moment danger was perceived or feared, processes which enabled the body to react to its utmost, calling forth every atom of energy for the life and death struggle, and, incidentally, of course, giving rise to most of the outward appearances already mentioned. These internal changes, moreover, gave the optimum conditions for the essential muscles of fight and flight. In fact, there was installed as complete a mobilisation as a Continental Power at war.

It is on the autonomic nervous system that this mobilisation depends. Its chief characteristic, I need hardly say, is that it controls all the involuntary and unstriped muscle of the body; and on this the whole interior economy of the body depends.

This extensive innervation is divided into three parts: the cranial, sympathetic, and sacral.

The cranial autonomic system has a restricted distribution. As a whole it acts as a conserver of the bodily energies and a builder of reserves.

The motor oculi nerve narrows the pupil of the eye thereby shielding the retina. The chorda tympani secretes the saliva for digestion. The vagus promotes the secretion of gastric juice in the stomach, inhibits the action of the heart and lungs, thereby resting these organs, gives tone to the gastro intestinal tract, and provides the stimuli for its necessary movements.

The sacral autonomic is allied to the cranial in its mildly positive function of the internal service of the body. Its action, apart from the genitals, can be summed up as that of *emptying*. The rectum and bladder on becoming distended are evacuated by this innervation.

The third division is the sympathetic system. Its fibres are found all over the body; its action is diffuse. It constricts all the small arteries and the arterioles, especially those of the skin and of the

abdominal viscera, keeping their walls in a state of tone; it accelerates the heart; it dilates the bronchioles, giving more lung ventilation; it supplies the sweat glands; it is motor to the muscles of the hair and the sphincters of the bladder and alimentary canal, causing them to close; it dilates the pupil of the eye.

This brief resumé shows the sympathetic to have a most diffuse and extended action, an action which is the direct opposite of the cranial and sacral autonomics. *Where* the cranial inhibits the heart, the sympathetic accelerates it; *where* the cranial is motor to the stomach and intestines, the sympathetic is inhibitory, stopping digestion. In fact, the sympathetic is a spendthrift and expends "in riotous living" what the cranial and sacral systems have been instrumental in building up.

The sympathetic is infinitely the stronger. Thus, in great emotion, as fear, the cranial and sacral are overwhelmed. The sympathetic is the preserver of the body; it is the power that mobilises the utmost powers of the individual for the struggle; the purely vegetative functions go by the board; those processes which are not of direct use are inhibited. Digestion, as a whole, ceases.

Pavlov demonstrated this on the dog by fistulæ in the œsophagus and in the stomach; by the former he "sham fed" the animal, by the latter he examined the secretion of gastric juices. He produced strong emotion by means of a cat. There was no secretion of gastric juice, where before it had been copious.

Strong emotion inhibits peristalsis; it is stated that, on a nervous patient being X-rayed for the first time, the test meal may remain in the stomach as long as six hours. It is well known that neurasthenic people or persons afflicted with grave anxieties suffer from bad digestion.

Another example of emotional disturbance is the Indian "Ordeal by Rice." The suspect was given dry rice to chew; if, after the specified time it was shown to be still dry, the man was guilty. This may not mean justice, but it shows that the man was so frightened and overwrought that his salivary secretion was inhibited, giving the parched mouth of fear.

Besides the inhibition of peaceful and vegetative processes, the sympathetic gives rise to many positive changes most beneficial for getting the utmost efficiency in the expected struggle—fight or flight.

Cannon has shown the great part played by adrenalin. On stimulation of the sympathetic either artificially, or naturally, through fear or anger, adrenalin is quickly conveyed in the blood stream all over the body. It has a specific stimulating action on the sympathetic itself, therefore increased output of adrenalin, a cumulative process. Whatever effect the sympathetic has this is increased by adrenalin, which itself has specific actions of its own besides.

Cannon showed that adrenalin is set free in emotion, and demonstrated its effect on unstriped muscle. He took strips of intestine, kept alive, and rhythmically contracting, in oxygenated Ringer's solution. He took blood from a quiet and undisturbed cat, which he termed "quiet" blood, and showed that the intestine continued its rhythmic contraction in it. He then frightened the cat thoroughly with a dog, and again took some blood—"excited" blood. On immersing the intestine in this blood, rhythmic contraction ceased and relaxation occurred; on replacing with "quiet" blood contractions were resumed. In the "excited" blood the presence of adrenalin was shown, and one part in three million gave results. As there is an effect on the intestinal tract, so there is a marked effect on the arteries and arterioles.

In severe physical strain one of the essential factors is the adequate blood supply—that is, an increased blood pressure. This is obtained by constriction of the arterioles and arteries. This is especially marked in the arteries of the abdominal tract, which, on stimulation of the sympathetic, are very strongly contracted; the large volume of blood, normally contained in this tract, being forced to the periphery, is a very important factor in raising the blood pressure (and at the same time eliminating digestive functions).

Oliver and Schäfer showed this by taking separately the volume of the abdominal viscera and the volume of the limbs, before and after injecting adrenalin. They found that the volume of the former decreased, and the latter increased in volume to a marked degree. The heart being an essential organ, its blood supply is not subject to this constriction. Adrenalin has been shown to dilate the coronary arteries. Adrenalin has its effect on the lungs. Cannon found it lessened the tone of the bronchioles, thereby increasing the capacity of the lungs for forced respiration.

Elliott, Cannon, and others have shown what important actions adrenalin has on skeletal muscle. When it is in circulation the liver pours out its stored up sugar to supply additional energy. If this sugar is not used, as would be the case in emotion, where no motor action ensued, it is excreted—glycosuria.

Smilie, U.S.A., found sugar in the urine of most candidates after a hard examination and "viva voce."

Fiske and Cannon found sugar in the urine of five substitutes, who had not been called on to play in an inter-collegiate football match; also its presence was shown in the urine of spectators who had shown enthusiasm. In all of twelve cats frightened glycosuria was present in a few minutes.

After repeated action it is well-known that muscle is fatigued; it no longer responds readily to stimuli, which before were enough to produce contraction;

that is, the threshold is raised. Adrenalin has a remarkable effect in counteracting this fatigue. It might at first sight be thought to be due to its action on the nerve endings. Cannon and his assistant Gruber showed that it acts on the muscle substance itself. Muscle in which all nerves had degenerated reacted, as does normal muscle. Where a rest of 40 minutes or upwards was required to restore the original threshold of muscle out of reach of adrenalin, five minutes, or less, sufficed, when adrenalin was in the circulation.

Another general action of adrenalin is its hastening of the coagulation of the blood. Another protective mechanism! Obviously a most valuable one when every drop of blood is so much energy lost. Cannon found that this action disappeared, however, if the liver was cut out of the circulation.

Cannon sums up: "Adrenalin set free in pain, fear and rage would put the muscles of the body unqualifiedly at the disposal of the nervous system; the difficulty which nerve impulses might have in calling the muscles into full activity would be practically abolished; and this provision, along with the abundance of energy supplying sugar, newly flushed into the circulation, would give the animal the best possible condition for putting forth the supreme muscular effort."

Other internal secretions have been stated to be activated in emotion; for example, the thyroid often enlarges after continual worry, and gives the symptoms of the marked nervous irritability and increased pulse rate of Graves' disease. The post pituitary has been found to bring sugar out of the liver, as does adrenalin. So it is likely that the internal secretions have some sort of co-ordinated action.

The superhuman strength and physical feats, such as running and jumping, well known in panic and fear, are easily explained by all this energy mobilised in the system—feats which no normal individual would attempt or perform. Take as example the astounding escapes in outbreaks of fire, where terror gives a man strength to swing across on telegraph wires to safety over a street maybe a hundred feet below. Or, again, the formidable obstacles the most unathletic people have cleared in their escape from the attentions of the local bull.

Fear, to repeat, is not necessarily followed by flight any more than mobilisation of the army is followed by war. What decides this? What makes man above the lower animals, who, when confronted with danger, merge their emotion and motor action together in headlong flight?

What makes our personality and decides our action? Psychology tries to tell us. Baldwin divides consciousness into the three great classes of fact in mind, which make it up—

Firstly—Intellect; "I know something," referring to an object or thing.

Secondly—Feeling: "I feel somehow," an affective state lacking objectivity; consciousness is itself affected; it includes fear and pain.

These two divisions may be combined together in any degree; *together* they may formulate the simplest bodily feelings or the highest emotions.

The third division is the will: "I do something." This is distinguished from the other two by a characteristic foreign to them: the sense of effort and exertion, exhibited in mental attention, choice and resolution.

Apply this to the average soldier during bombardment in a front line trench! He *knows* the danger of shells; he has seen their effects. He may imagine there is an attack following. He feels the call of self-preservative instinct inherent in every living thing. He feels fear. Simultaneously by some form of brain discharge his sympathetic is stimulated; his body is mobilised, giving the typical outward characteristics of the fear emotion. Energy is placed "on tap," as it were. This pent-up energy simply asks to be used, and why not follow the precedent of his ancestors in prehistoric times, and run away? It would be more physiological to convert this energy into action than waste it.

His will comes into play. By it he inhibits any attempt at flight. It may be a sense of duty impelling or the fear of being dubbed a coward, a greater fear than that for which the present danger is responsible. Will seems to be an output of energy, as it always presents itself as an effort. It, of course, varies in every individual. Occasions occur where the will is insufficient to combat the inherent instinct of flight, and intense fear gives place to the dreadful panics and "sauve qui peuts" seen in every war. So the powers that be, who train and command armies, built up a system of training and discipline—a training that aimed at making the carrying out of orders automatic and as a matter of course—in fact, an attempt to make obeying as much of an instinct as flight. They also drew up the Manual of Military Law and brought to their aid the greater fear of court-martial and ignominious death.

How far this artificially produced instinct will maintain armies in the face of grave crises has been time and again demonstrated. But beyond a certain point the more primitive and therefore the stronger calls of self-preservation defeat it. The issue becomes the question of individual will. The weaker give way. Gregarious instinct in man is as primitive as fear, and one faint heart may demoralise a brigade.

Flight and panic are not the only modes in which fear exerts itself. A man is often so overcome with terror that he cannot move; he cannot act in any way; he becomes a shivering useless wreck rooted to the ground. I take this as another primitive form of self-preservation, a "throw-back" beyond that of muscular action of flight, the immobility such as the hare assumes to escape detection.

Now consider the man who feels fear, but does not run away. He carries on with his duty. Though by his will he has inhibited the conversion of his mobilised energy into flight, he still has the products in his system. His features and general appearance probably indicate a discharging sympathetic, palpitating heart, rapid pulse, laboured respiration, trembling muscles. He may find he cannot light a cigarette, and may be quite unable to prevent his knees knocking together. He has a profuse sweat, and his face is pale and drawn; his pupils are dilated; his mouth is parched and dry.

Adrenalin and other internal secretions are in his system. By their activities they are rapidly draining his supply of energy. His sugar is poured out and goes unused. His heart and lungs are wearing themselves out and impoverishing his blood supply, all to no purpose. He is like a short-circuited battery, discharging with no work done and harmful by-products. The effects are most harmful, if not toxic. The brain itself must also soon feel the effects of the constant outflow of nervous energy; the sympathetic must in time exhaust it.

All the unused products of the mobilisation in the circulation, added to a poorer and poorer blood supply, are bound to tell. Crile has shown the different histological appearances of a rabbit's and a dog's brain after two kinds of activity. The dog was allowed to jump round and frighten the rabbit for some time; it had been very excited, but had taken violent exercise. The brain section showed but small changes from normal. The rabbit had been terrified and had not moved. His brain cells gave the appearances of complete exhaustion.

Anyone who has had to spend a day or two while unseen villains lobbed H.E. into adjacent traverses knows that "tired feeling"—it may get to the pitch of welcoming a direct hit from the next salvo. It stands to reason that all these emotional changes must impair the will, which, as pointed out above, was energy of some kind unknown. The soldier begins to become "windy," his threshold to fear is lowered. Actually, for his physical well-being, flight would have left him in a much sounder condition. Need I say that this cure is not advocated, nor are such prescriptions encouraged on active service!

But *given* muscular work, the effects of fear are not nearly so harmful. Take digging-in. The shell-fire may be as intense as it was in the case of passively enduring it in a trench. *Now* fear is of assistance in getting below ground; it gives additional energy to the shovel, generally so dilatory on manœuvres; the body gives its maximum output. Or take the attack. It is common knowledge that going forward through intense barrage is infinitely preferable to inactivity in a bombarded trench.

Any preoccupation plays a very great part in countering fear, by leading the activities of the brain through other channels. The above examples are as much preoccupation as they are methods of using up the fear-produced mobilisation. Thus, many officers, struggling with their fear, have found they were much steadier if they kept on the move up and down their command continuously during bombardment. Some men, and most valuable men they are, have the knack of making facetious remarks, or playing the mouth organ at the most critical times. It may be rather labouring the point if one says that the laugh and song, they raise, work off some of the toxic munitions in themselves and their companions. Be that as it may, it relieves the tension. The moral effect of the platoon's funny man is inestimable.

Now it seems to me that a brave man must have a strong will. I define him as being one who, under whatever conditions, has enough will power left at his command to make his body carry out his wishes, and to inhibit any self-preservative tendencies, when necessary. A brave man knows the dangers and he weighs the risks. *If* he considers any action a *risk*, then I maintain he must know fear. Though this is given no chance of getting the upper hand, it must have some effect on his interior economy, and I maintain no man wins a V.C. who hasn't a trace of sugar in his urine.

There are apparent cases of men who are not supposed to know fear. If this is so, I do not consider they are normally made up. Anyhow, if such men there are, they are unfitted for a command. If they do not know fear, they are incapable of weighing risks, and it is murder to entrust men's lives to them. These men would be pathological, not having the normal response to the stimuli of danger. The tortoise and porcupine, because they carry their natural protective mechanism on their backs, show no motor action in fear, so cannot experience emotion. They are low in the scale of the animal world; in classing such men with these animals, I offer the explanation, which I doubt if you will accept, that they are a "throw-back" in evolution.

Many deeds earning and meriting the highest praise have been performed by men in a "blue funk." Their struggle against their fear has been so great that, I venture to say it, they have reproduced Darwin's Principle in Evolution—that of antithesis. Darwin demonstrated this in many expressions of emotion. A dog, crouching down belly to ground and wagging his tail fawning on his master, was showing his devotion by actions, which were typically the very opposite to hate and ferocity—the bristling, arched back, stiff legs and erect tail. So the man in a "blue funk," by wishing to do the opposite to flight, astonished himself and his companions by fighting spontaneously as never before, and utilising his fear-produced mobilisation for superhuman deeds.

This war has produced an enormous number of nervous "crocks," types of casualties unknown in

former wars, except, perhaps, the Russo-Japanese. Who ever heard of "shell-shock" in the Boer War! In this war the amount of men invalided out of the service for shell-shock, hysterias and neuroses of all sorts, must approach the number invalided through wounds. Need I dwell on the reason? War has become so frightful that even at home it was possible to get shell-shock from the raiding Gotha. There is a limit to the endurance of all men. No sleep, erratic nourishment, impaired digestion, dirt, wet, and discomfort, in themselves, are enough. They form a ready soil for the undermining influences of fear and the constantly discharging sympathetic. For efficiency, rest out of the line, sleep, warmth, and security are essential. If not forthcoming, the system is bound to "crack up." Nerve and tissue must succumb to this constant mobilisation, the products of which are neither used nor replaced. The man becomes highly strung, "windy." He loses his confidence in himself; for instance, in judging the fall of shells by their sound. He jumps if anyone merely taps his pipe out.

At the same time, in his mental struggle against his flight inclinations, he has been damming up his fear, and keeping concealed his emotions, only by immense effort. One day an event occurs, which just overcomes this "repression," as psychologists call it. It may be only a trivial event, but the tide is let loose. He becomes totally unfit for duty and goes down the line; nor is he likely to return. It takes months or years for him to build up his system and brain power again, or these may have been taxed beyond repair. In hospital they find he also has a disordered heart, nephritis, and what not!

In fact, to sum up, he has been incapacitated by the very protective mechanism, with which nature has provided him for his struggle in life; he has been undone by his sympathetic, which "meant well"!

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Capt. C. G. Haynes, K.R.R.C.

SIR,—I have never seen any mention of C. G. Haynes in your "Honours" or "Casualty" columns.

The many pre-war people now back at the hospital will hear with great regret that Graham Haynes was reported "missing" on October 23rd, 1918, on a reconnaisance flight, and that nothing up till now has been heard of him.

He joined the Artists' Rifles at the outbreak of war and landed in France with them in October, 1914. He was commissioned in France in April, 1915, to the 4th Battalion King's Royal Rifle Corps, and was wounded in May at the second battle of Ypres. He returned to the front to the 17th Battalion K.R.R.C. in September, 1916, and won the M.C. at the Schwaben Redoubt:—

> "He led bombing attacks with great courage and determination, and finally, after bombing for one and a half hours, was able to capture two officers and fifty men."—*The Times*, Dec. 19th, 1916.

In the fighting in 1917 in Shrewsbury Forest, Ypres Sector, he won a bar to the M.C.:—

> T/Lieut. (A/Capt.) C. G. Haynes, M.C., K.R.R.C.
> "He successfully led attacks on three strong points, and later, aided by one man, he captured a dug-out, and took two officers and four other ranks prisoners."—*The Times*, Nov. 26th, 1917.

In November, 1917, he was seconded to the R.F.C., and was at home training as observer and then as pilot until August, 1918, when he again went to France. He became a flight commander and regained his acting captaincy, and saw heavy air fighting in September and October.

I hope you will be able to find space for this belated account, or part of it, in your next number. I fear after all these months his chance is small. It is only to be hoped that he may yet turn up all right, and we shall have the luck to see him again playing "rugger" for the hospital.—Yours sincerely,

R. J. HODGKINSON.

DEAR MR. EDITOR,—Your first paragraph in Passim on March 8th, and the correspondence in the same number deal with two distinct proposals, that a Hostel for students should be established at Honor Oak Park or similar locality, and that the money to found such a Hostel should be got from the fund in memory of Guy's men who have fallen in the war.

With the first proposal all are in sympathy, with the second you "anticipate criticism." It is this criticism that I wish to voice.

Consider Arras, think of a bombing raid, and then remember that the high explosives fell in Arras, not during a few hours of a few nights, but hour after hour, day in and day out, till the homes of the inhabitants had fallen about their heads or their corpses and the city had become as it now is. In giving their lives those whom we wish to commemorate saved our homes from this. Try and recall or picture a retreat; a narrow hillside road inches deep in mud with a cold wind blowing and a hard rain falling, the inhabitants have got wind that the troops are to retire, just a few hurry down the road, then more and more till by dusk the road is full of them, with such of their household gods as they can bear away with them, A few able-bodied men pass with an overloaded pack donkey, and then a family with a cart and improvised harness, another family without any vehicle, little children toddling barefoot through the mud clutching on to the skirts of the mother, who carries one yet younger, while the father drives along the only cow. Then,

as darkness falls, troops begin to come along, a battery of howitzers with a sick man tucked on to every gun, ambulance wagons full of wounded drawn by animals already tired, pack animals are being taken off the road to get a few hours rest and stop all the traffic, while refugees dodge under the heads of frightened beasts to get past the block only to be pushed off the road into the gutter or up the embankment as the troops come on again. Then the rearguard overtakes them and many are left exhausted by the wayside to fall into the hands of the enemy from whom they have fled, their labours all in vain. In imagination stand by the dark roadside the long night through and hear them pass nearly silent except for the patter of their feet upon the way, and remember that those who have died have saved our babes from this. We can never repay to them the debt we owe, but it seems to me that those of us who have come solvent through this war without loss of life or limb should not touch one penny of this money which belongs to them. When a man goes into action he is afraid, and he masters that fear, if he is alone in the world it is not so hard, but when he has a fiancée or young wife he thinks of her struggling on alone without that support that he had hoped to give her, but still he knows that she can fight her way herself; but when he also thinks of children and of his wife trying to fight on to keep herself and educate them, it is very hard indeed. He always has faith that those he left behind will look after them, he thinks a lot of their education because up in the field he has learnt the enormous importance of it; and until those children have been clothed and taught I feel it would be a crime on our part to use the money for what is after all our own personal use.

I enclose a memorandum which may be useful as a basis for further discussion. To carry out the proposals made in it a record of the children of those who have fallen should be made at once so that we can find out how much money is needed for these purposes.—I am, dear sir, yours faithfully,

10, Welbeck Street, W.1. T. B. LAYTON.
March 16th, 1919.

Memorandum on the War Memorial Fund.

1. That a simple tablet bearing the names of those who have fallen should be erected in some conspicuous place in the hospital.

2. That a small sum be invested to pay for the cleaning and repair of the above tablet for ever.

3. That all other monies be invested in the name of the Governors of the Hospital as Trustees for the following purposes :—

a. To keep from starvation the dependents of those who have fallen when they are unable to keep themselves,

b. To provide such education for the children of those who have fallen as their parents might reasonably have expected to provide for them.

c. To endow Scholarships in the Medical School of Guy's Hospital for which the children of those who have fallen shall be eligible.

d. To assist financially by grants or annuities anyone connected with the hospital who has lost a limb or sight, or otherwise deteriorated in his wage-earning capacity as a result of the war.

e. To assist financially by grants or loans, with or without interest or security, anyone connected with the hospital who is in financial difficulties as a result of the war.

4. That under "those who have fallen" or "anyone connected with the hospital" shall be included any past or present Governor of the hospital, past of present member of the teaching staff of the hospital or medical school, past or present student of the hospital or member of the nursing staff, or anyone who at the time that he joined His Majesty's Forces or took on other whole-time war work was an employee of the hospital, medical school, or other institution or estate which is administered by the Governors of Guy's Hospital.

5. That the word "fallen" shall include anyone who has died from any cause since the outbreak of hostilities while a member of His Majesty's Forces, or otherwise wholly employed on work connected with the war.

6. That a Council to advise the Trustees on the allocation of the funds should be elected, and should include representatives of the Governors, the Medical Staff, the Medical School Staff, old Guy's men, Students of the Hospital, past or present members of the Nursing Staff, and the employées of the Hospital, Medical School, and other institutions administered by the Governors of Guy's Hospital.

7. That when the money is no longer needed for the purposes specified under 3 above, it shall be put to such other purposes as the trustees shall decide.

Papers by Guy's Men.

R. King Brown, M.D., D.P.H.: Suggestions for the teaching of preventive medicine.—*Med. Officer*, March 8th, 1919.

Arthur F. Hurst, M.A., M.D. Oxon., F.R.C.P., Lieut.-Col. R.A.M.C., and J. L. M. Symons, M.D. Cantab., Major R.A.M.C.: Hysterical element in organic disease and injury of central nervous system.—*Lancet*, March 8th, 1919.

H. C. Lucey, M.D., B.S., Capt. R.A.M.C.: The nasal plug as a guard against influenza.—*B.M.J.*, March 15th, 1919.

E. G. Slesinger, M.B., B.S., B.Sc., F.R.C.S.: Hunterian lecture on the early treatment of compound fractures and other severe injuries of the upper limb.—*Lancet*, March 8th, 1919.

Guy's Hospital Dental Society.

A meeting of the Society was held in the College Smoking Room on Friday, February 14th, at 8 p.m. The President, Mr. M. F. Hopson, was in the chair.

The Secretary, Mr. Herbert, read the minutes of the last meeting which were passed for signature. He also announced that the Annual Dental Dinner would be held on May 10th at the Connaught Rooms. Mr. F. B. Bull has kindly consented to act as Dinner Secretary, and all communications should be addressed to him at 24, St. Thomas's Street, or at the Hospital. A casual communication was read from Mr. Woodward.

There were present as visitors: Lt. Gribble, Lt. Caldecott, and Serg. Jesse Worgan of the N. Z. Dental Corps. They were asked to consider themselves members for the evening, and invited to take part in any discussion.

Mr. Hopson then addressed the meeting. He said that it gave him great pleasure to once again be our President. It was the third time he had held that office. As we all knew, he was a busy man, and, when he was approached by the Secretary, he at first refused, but when pressed he consented to do so under certain conditions. One of those conditions was that he should not make a presidential address, and therefore he was not now going to do so.

He extended a hearty welcome to those members who had returned from active service, and made reference to those "who would never tread the old colonnade again," but whose memory, he felt sure, would live for ever.

He was glad that such an appropriate subject had been chosen for discussion at our first meeting, because it was an all important one, and upon which the whole future of the profession depended. He was especially interested because he took an active part in what was being done at the present time.

He referred to the report of the Commission, before which he had given evidence. He had seen the report and it would very shortly be published. He could say very little about it, but, although there were things in it with which he was bound to disagree, he thought, on the whole, it was very good. He expressed the hope that its weak points would not arouse too much criticism, because if they did, he was convinced that it would only retard the framing of the bill which was so vitally necessary to the welfare of the profession.

He then called upon Mr. Coplans and Mr. Greenwall to read their papers on "Reconstruction and its relation to the Dental Profession." The chief points of Mr. Coplans' paper were—

He began by paying fitting tribute to our victorious Navy and Army by whose sacrifices we were enabled to begin reconstruction. He thought of the tasks we had before us as more than reconstruction. Resuscitation was a better word—"the resuscitation of a noble profession, starved and perishing in a world of prejudice and quackery."

As a recognised learned profession we had been in existence for half a century, and our position at the present moment was deplorable. Whilst there were only five thousand Licentiates of Dental Surgery on the register, there were many thousands of unregistered practitioners who preyed upon an ignorant and unsuspecting public.

For this state of affairs he blamed the dental laws of this country, and, to some extent, the tardiness of the General Medical Council in doing anything to alleviate the condition of things brought about by them.

He argued that if dental surgery was a speciality of General Surgery (and it is looked upon as such), then the qualification should have the same standing in all respects as that of a general surgeon.

If this could not be so, then, he suggested the establishment of a Faculty of Dentistry in all the Universities with a degree, say, of Doctorate of Dental Surgery.

He also urged that a General Dental Council should be formed composed entirely of dental men, or at least adequate representation on the General Medical Council. As regards examination reform, he thought that something after the pattern of the American system could be adopted with advantage. In America each student is allotted so many marks or counts for the work he has done, and when he goes to his yearly examination these count in his favour.

He was also in favour of the examining board being composed of the teachers and professors with whom the student had worked, as he thought they were better able to judge whether a man was fit to practice.

With reference to the syllabus, he was not in favour of lowering the standard of the entrance examination in arts. He thought that there should be more co-ordination between the dental and the medical subjects having a bearing on that branch of surgery. Biology might with advantage be included in the Preliminary Science, and Mechanics could better be spread over the whole course, and even included as a final subject.

In alluding to the teaching, he was of opinion that a full-time Dean of the Dental School should be appointed with the same powers and privileges as that of Dean of the Medical School, and that he should receive adequate remuneration for his services. All lecturers, teachers, and professors should be adequately paid, and proper provision should be made for research work and post-graduate courses. Proper provision should be made for organised propaganda amongst the laity for the furtherance of dental ideals.

In conclusion, he said, "Let us, therefore, revise our syllabus and hospital training, and with quackery at an end, come into our own as a highly-skilled and honourable profession."

Mr. Greenwall followed with his paper, the main points of which were:—

He considered it firstly from the point of view of National Health. He urged the teaching of the rising generation the value of oral hygiene and the evils of unqualified practice. He considered that this could very well be done through the medium of the press and cinematograph.

He then referred to the teaching in the dental schools. He considered that there should be more fraternity between the medicals and dentals. Also, the enforcement of four years' hospital training would, in his opinion, be an improvement.

He would like to see more attention given to the teaching of ethical practice.

He urged that every Dental Surgeon should belong to the British Dental Association, and, as well as belonging to it, take a keen interest in all its proceedings.

He was also very keen on the universal adoption of school cliniques for the treatment of children's teeth.

A lively and interesting discussion ensued, in which Mr. Coplans' paper came in for a good deal of criticism.

It is interesting to note, however, that Mr. Hopson agreed with Mr. Coplans on two important subjects—the curriculum and the board of examiners. He said, however, he thought one external examiner should be on the board.

Others who took part in the discussion were: Mr. Bull, Mr. Forty, Mr. Flukes, Lt. Gribble, Mr. Griffin, Mr. Gaffney, Mr. Herbert, Capt. Johnson, and Mr. Lauer.

The attendance at the meeting was very poor, and the committee express the hope that in the future members will make a greater effort to be present. Full particulars of the next meeting will be announced in due course.

The foregoing should have been published in the last issue of the GAZETTE, but was held over for the appearance of a précis of the Report referred to in the text. It is known officially as "The Report of the Committee appointed by the Lord President of the Council to Inquire into the Extent and Gravity of the evils of Dental Practice by Persons not Qualified under the Dentists Act." It can be had at H.M. Stationery Office, Kingsway, or from any bookseller, price 6d. Everyone is strongly advised to procure one and study it well.

Pupils' Physical Society.

A meeting of the above was held on March 18th, when Dr. Ryffel kindly occupied the chair. Like the last, this meeting took the form of a Clinical evening, several interesting cases were shown, and the discussion was good. In addition a fully representative Committee was elected, viz., A. A. Forty, D. M. P. Whitcombe, G. B. Dowling, F. W. Reitz, E. J. Gaffney, G. T. Helsham, A. E. Sawday, M. Cohen, T. G. D. Bonar, G. P. Lindsay, W. M. Brown, and M. Maizels.

A Case of Submucous Cervical Fibromyoma delivered with Obstetric Forceps.

E. T., æt. 43, married, was admitted to Queen on February 24th, under Mr. Chapple, complaining of a dull aching pain in the hypogastrium and a thin watery discharge which had been continuous for the last five months. Three weeks before admission she had a flooding. Her bowels had been extremely sluggish, and she complained of frequency of micturition. Vaginal examination revealed a large round, smooth tumour, about the size of a rather small fœtal head, which filled the vaginal cavity and obscured the cervix.

Submucous cervical fibroid was diagnosed, and on February 25th Mr. Marston operated. The tumour was grasped with the hand and drawn steadily down until the pedicle could be felt between the two fingers. Long scissors were used to cut through the pedicle and thus free the tumour. Many unsuccessful attempts were then made to deliver the fibroid, until it was suggested that obstetric forceps might do the trick. Accordingly forceps were applied in the ordinary way, and the tumour was delivered with the greatest ease. The fibroid measured $4\frac{1}{4}$ in. by $3\frac{3}{4}$ in. in diameter.

I am indebted to Mr. Marston for permission to publish this note.

DRESSER.

Abstract of Summary of Anæsthetics and Operations for the Year 1918.

THE number of cases in which general anæsthetics were administered was 7,004, among which were 39 intratracheal insufflations of ether, and 6 of ether and C.E. Spinal analgesia was also employed in 15 occasions, and on 10 occasions spinal analgesia followed by a general anæsthetic. The total number of operations was 6,814 in wards (Bright Ward excepted), Special Departments, Out-Patient Departments, and Surgeries. There was no death under anæsthesia.

There have been 4933 cases of general anæsthesia in the Dental Department—4,673 under nitrous oxide gas, 259 under ethyl chloride, and 1 under ether.

Operations done on the medical side are entered under the assistant surgeons corresponding to the physicians or assistant physicians in charge of the wards, the table below showing how many operations are actually performed in these wards:—

ANÆSTHETICS.

A.C.E.	307
C.E.	875
Chloroform	241
Ether (including gas and ether)	142
Gas and gas and oxygen	1,079
Intratracheal insufflation of ether	39
Intratracheal insufflation of ether and C.E.	6
Spinal analgesia	15
Spinal analgesia followed by a general anæsthetic	10
Other anæsthetics and sequences	4,305
	7,019

ADMINISTRATION OF ANÆSTHETICS.

Staff Anæsthetists	1,309
Visiting Staff	855
Resident Surgical Officer	36
House Officers	4,133
Other Qualified men	686
	7,019

OPERATIONS.

Tabulated according to Wards and Departments.

Astley Cooper	250
Cornelius	205
Lazarus	219
Job	286
Naaman	263
Luke	192
Patience and Samaritan	319
Evelyn	144
Charity	257
Dorcas	329
Lydia	370
Martha	315
Eye Wards	724
Addison	56
Mary	19
Stephen (Officers' Section)	93
Esther	38
Queen Victoria	539
Clinical	43
Isolation	18
Out-Patients	1,724
Front Surgery	341
Back Surgery	48
Nurses' Sick Room	27
	6,814

Turning to the General Wards it may be noted that the totals of operations are as follows:—

Surgeons	847
Assistant Surgeons	456
Specialists	151
Resident Surgical Officer	386
House-Surgeons and Assistant House-Surgeons	819
Dressers	451
	3,110

The remaining 92 operations, bringing the total up to 3,202, were performed by other operators.

It should be remembered that no account is taken of operations done either under local anæsthesia or without anæsthetics at all.

Operations in the Obstetric Department (Queen Victoria and Patience Wards) number 569, of which 138 were performed by the Obstetric Surgeons, 252 by the Obstetric Assistant, 108 by the Obstetric Residents, while 71 operations were performed by other operators.

The operations upon ophthalmic cases in the wards number 110, of which 91 were done by the Ophthalmic Surgeons, 1 by the Ophthalmic Assistant, 5 by the Ophthalmic House Surgeon, 1 by Ophthalmic Dressers, and 12 by other operators.

There were 666 operations for Throat and Ear Diseases in the Wards, 460 by Surgeons, 106 by Clinical Assistants, 32 by the House Surgeon, 58 by Dressers, and 10 by other operators.

In the Genito-Urinary Department, 75 ward operations were performed, 22 by the surgeon, 13 by the Resident Surgical Officer, 28 by Dressers, and 12 by other operators.

In the Venereal Department there were 8 ward operations performed.

In the Front and Back Surgery 389 operations were performed, 1 by the Resident Surgical Officer, 68 by House Surgeons and Out-Patient Officers, 53 by the Assistant Casualty Officer, 257 by Dressers, and 10 by other operators.

In the General Out-Patient Department 494 operations were performed, 442 by Dressers, 9 by House Surgeons, and 43 by other operators.

In the Special Out-Patient Departments there were 1,076 operations upon Throat and Ear cases, of which 41 were done by the Surgeon, 55 by the Clinical Assistant, 14 by the Ophthalmic House Surgeon, and 960 by Dressers, while 6 were by other operators; 1 operation by a Dresser was performed in the Obstetric Department, while 153 operations were performed in the Orthopædic Department, 47 by the Surgeon, and 106 by Dressers.

Appointments.

R.A.M.C.

Lieut. G. Wilshere, R.A.M.C.(D.) to Basra, Mesopotamia.

To be Lieut.-Col. whilst specially employed.—Major A. C. Osburn.

To be Lieut.-Col. whilst in command of a Medical Unit.—Lieut.-Col. A. C. H. Gray.

To be Acting Majors.—Temp. Capts. N. E. Kendall, A. Scott.

To be Acting Major whilst specially employed.—J. F. Venables.

Lieut. (Temp. Capt.) to be Capt.—(Acting Major) J. Le F. Lauder, D.S.O., M.C. (and to retain his acting rank).

To be Capt.—Lieut. E. H. Bryant, N.Z.M.C., to date from February 1st, 1919.

The following Officer relinquishes the acting rank of Major on reposting—Capt. H. F. Joynt.

Hedley Visick, L.D.S., to be Dental Lieut. attached R.A.M.C.

Officers relinquishing their Commissions.—Major M. C. Wetherell; Temp. Major E. D. Hancock (on ceasing to be employed with Guildford War Hospital, and retains the rank of Major); Temp. Capts. (retaining the rank of Capt.) H. H. Carter, H. C. Fox, C. P. Symonds, R. D. Bridger, F. L. Aubrey; Lieut. (retaining the rank of Lieut.) C. Edwards.

Volunteer Force.

City of London R.A.M.C.—Temp. Major B. Duke to be Temp. Lieut.-Col.

Civil.

W. H. Trethowan, M.B., B.S., F.R.C.S., has been invited to become Surgeon to the Royal National Orthopædic Hospital.

W. P. Ker, M.R.C.S., L.R.C.P., to be District Medical Officer, Rugby Union.

Football.

ASSOCIATION.

GUY'S v. LONDON HOSPITAL.

Played at Hale End, on Saturday March 8th. Although Guy's were beaten by 6 goals to 1, the game was not so one-sided as the score seems to indicate. Indeed, from the kick-off Guy's held their own well, and after a few minutes were the first to score from a good centre from the left wing. After this the London forwards settled down to some good work and severely tried our defence. Hore saved well many times, till their inside right scored with a beautiful shot into the corner. After this it was clear that Guy's would have a hard time to keep their end up, and before half-time London drew ahead by scoring two more goals.

In the second half the play was very much the same. Our forwards could never keep the ball long, and consequently the defence was very hard pressed, though for nearly half an hour they kept the opposing forwards at bay. Shelswell at centre half did some good defensive work, and Hore, who was never allowed much respite, again cleared several dangerous shots. The three further goals they scored did not give him a chance. Guy's were beaten by a better and heavier team in a thoroughly sporting and enjoyable game. Team:—

W. G. Hore (goal); H. A. H. Harris, E. F. Hewlitt (backs); A. N. Other, A. H. Shelswell, W. G. Booth (halves); E. R. Webb, H. B. Jones, G. P. Lindsay, W. A. Caldwell, J. D. S. Thomas (forwards)

Birth.

LEIGH.—On March 3rd, 1919, at Cairo, the wife of Major H. V. Leigh, M.B., R.A.M.C., of a daughter.

Marriages.

GIBBINGS—ORD.—On December 11th, 1918, at St. Catherine's Church, Uitenhage, Cape Colony, by Rev. Canon Fleck, Reginald John Gibbings, L.D.S., R.C.S. Eng., younger son of late G. F. Gibbings, of Exeter, Devon: of Salisbury, Rhodesia, to Mabel Constance, third daughter of Mr. and Mrs. Robert Ord, of Uitenhage, Cape Colony.

MAWER—BRIGGS.—On February 5th, at St. Martin's Church, Leeds, Capt. J. W. Mawer, L.D.S. Eng., of Leeds, to Mabel Clissold Briggs, of Darlington.

G. B. D.
G. P. L.

GUY'S HOSPITAL GAZETTE.

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Passim.

RARELY has the hospital sustained so great a loss to the Senior Staff as in the first three months of this year, for we have to chronicle the farewell round of the Senior Physician, Dr. Lauriston Shaw, on Monday last, "completing (we quote from Mr. Forty's excellent speech) with Sir Arbuthnot Lane, and Sir William Hale White that triad of great Guy's men who have been translated to a Higher Sphere the Consulting Staff."

A large and representative gathering, including present students and former H.P.'s, followed Dr. Shaw on Monday afternoon when a demonstration on a case of Mitral Stenosis and Regurgitation was given in Mary. A move was then made to Addison where a clinical demonstration on several cases was made.

Dr. Shaw took the opportunity of reviewing the methods of clinical medical education, and deplored the modern and increasing tendency to employ didactic—so much in vogue on the Continent—in place of the older "Apprenticeship Teaching," where by the system of question and answer, the minds of the lecturer and student were brought more "en rapport." This has been the bed-rock of clinical teaching in London and more especially at this Hospital.

Dr. Shaw emphasised the importance of forming a Students' Council in this and all hospitals, for the purpose of making known to the authorities the needs of students, and the means by which they considered their teaching needs would be best met.

Later in the afternoon tea was served in the Hall of Addison, where a still larger gathering was entertained by Sister Addison to meet Dr. Shaw. It was a great pleasure to see Mrs. Lauriston Shaw and her son—with the Matron.

Then Mr. Forty, Dr. Shaw's last H.-P., most admirably expressed the mingled feelings of pride and regret, which were felt not only by those assembled in Addison, but by all Guy's men.

Dr. Shaw made a characteristically eloquent reply concluding "the best thing I can wish you is a career full of opportunities, and that you shall meet with that kindness, sympathy, forbearance, and affection from your colleagues that I have received from all with whom I have come in contact at Guy's."

At the conclusion of the ceremony the wards resounded with cheers heartily given for Dr. and Mrs. Shaw.

IN our correspondence columns will be found three communications on the subject of the Guy's War Memorial.

We would draw attention in particular to that from Sir W. Hale White, which fills the gap in our reasoning in favour of a more lasting memo-

rial. It is comforting to know that the Auxiliary Royal Army Medical Corps Funds not only exist, but are of such a nature as to be capable of very definite financial assistance to many. For we are told that "the committee is in a position to consider very sympathetically any application." It is of course an open question whether these funds could make provision in the same generous way as all Guy's men who have come unhurt through the war desire to see, and to which they feel it a privilege to be able to contribute.

In considering the demands likely to be made upon these funds, however, a few points should be borne in mind.

1. The vast majority of our Fallen are unmarried, and the number of orphan children likely to be small.
2. If there are any children, they are almost always young children who would not be coming on to Guy's for many years.
3. Of the children few probably would wish to take up medicine.
4. This being so it would seem probable that the funds already raised for the one purpose of aiding the education of orphans of R.A.M.C. will be found in all likelihood to be sufficient for that purpose. And we venture to suggest that, in view of the fact that there is so much to recommend the erection of a permanent War Memorial, a sharp look-out should be kept by the War Memorial Committee to prevent any overlapping in the provision of this financial assistance, and to make sure that any grants made should in no way take the place of those funds which have been raised solely for that purpose.

Our readers will recall a letter from Dr. Hurst containing a comment on our War Memorial Number with the proposal that ultimately a complete record of Guy's men who have served should be published under a separate binding.

We are authorised by Mr. F. J. Steward to announce that it has now been decided to make the next issue of the Guy's Hospital Reports a War Number. It will be published as usual at the end of the academic year, and promises to be a volume of historical interest and permanent value. We understand that in addition to the photographs of the fallen and lists of those who have served, both men and nurses, and an Honours list, it will contain articles of special interest relating to Guy's and the war.

We think that Dr. Hurst and all who like him desired some war record of their fellow students and colleagues that they could keep, will acclaim this as being likely in every way to meet their wishes, and we feel confident that the Editors of the Guy's Hospital Reports will produce a memorial of exceptional interest and one that will be prized and treasured by innumerable Guy's men.

If any of our readers have any information that would be of value to the editors in compiling this record they are asked to send it to Mr. F. J. Steward, who is most anxious that this should be complete and accurate in every possible way.

We have heard complaints about the way patients have lately been referred from the Front Surgery to the Infirmary. It appears that non-urgent cases instead of being sent to the Relieving Officer have been despatched direct to the Infirmary. This causes additional and unnecessary work because not all these cases become admitted to the Infirmary, certain of them being treated in their homes by the parish doctor. We feel sure it is unnecessary to remind those on duty at the Front Surgery of the correct proceedure in all except urgent cases.

On another page will be found an account of the Guy's Hospital Ball, which all are agreed was a singularly happy event, and upon which the Hon. Secretaries are to be congratulated. The substantial sum of £74 passes to the War Memorial Fund.

We have great pleasure in announcing that Dr. Thos. W. Spink Locke, of Cotham, Yorks, has promised to place in his Will a legacy of £50 for the Guy's War Memorial Fund, adding that it is hoped that others may be induced to follow his example.

Dr. Locke, who is ninety years of age, is probably the oldest Guy's man. He entered the Hospital in 1848, and qualified M.R.C.S. in 1855; he is a J.P. for North Riding, and for 27 years was Medical Officer to the 3rd Militia Regiment (Suffolk).

We offer our congratulations to Mr. E. C. Grey on whom the degree of D Sc. in Biochemistry has been conferred by the University of London.

The Annual Ladies' Night Debate was a striking success. The whole thing was on a far more ambitious scale than heretofore, the number present, nearly 200, taxing the resources of the college smoking room to the uttermost. The thanks of all are due to the Hon. Secretary for his untiring energy, and to Mr. Maizels for the remarkable ability with which he held his own in the face of such overwhelming opposition. The Debating Society has made a sound beginning and should be a very flourishing concern next winter.

GUY'S WAR MEMORIAL FUND.

	£	s.	d.
Brought forward	3,147	11	2
Hind, W.	5	0	0
Reynolds, L. L. C.	5	5	0
Heckels, G. W.	2	2	0
Hughes, E. C.	26	5	0
Malson, R. C.	2	2	0
Clowes, N. B.	1	1	0
Hare, E. C.	2	2	0
Ransford, W. R.	2	2	0
Bull, F. B.	10	10	0
Nathan, M. P.	1	1	0
Wright, G. A.	2	2	0
Anderson, C. T.	2	2	6
Minett, E. P.	10	10	0
Moore, Mrs. Harry Gage	2	2	0
	£3,221	17	8

The Physical Society.

A meeting was held in the Smoking Room of the College, on the 28th March, with Mr. Forty in the chair, when Mr. Whitcombe read a paper on "Hæmaturia"; the subject was treated very fully and all present enjoyed the paper. It was agreed that the next meeting should take the form of a Pathological evening on a date to be arranged later.

Appointments.

R.N.M.S.

The following appointments are announced by the Admiralty:—

Temp. Surg.-Lieut. R. P. Ninnis to the *Hercules*.
" " " G. A. S. Shacklock to the *Valiant*.

A.M.S.

The undermentioned Officer is retained on the Active List under the provisions of Article 150, Royal Warrant, for pay and to be supernumerary:—Col. G. T. Rawnsley, C.M.G., C.B.

Col. A. H. Tubby, A.M.S., has relinquished his duties as Consulting Surgeon to the Egyptian Expeditionary Force, and resumed his private work.

R.A.M.C.

Majors to Lieut.-Cols.—P. Paget, J. W. Nicholson.

To be Acting Major.—Temp Capt. E. Biggle, M.C.

The undermentioned Officers relinquish the acting rank of Major.—Bt. Major R. C. Ozanne; Capts. V. F. Southill, R. Felton, J. F. Robertson.

Capt. R. J. W. A. Cushing, R.A.M.C., has been appointed Senior Medical Officer, Chepstow and Beachley Camps; Officer i/c Military Hospital, Chepstow; O.C. Detachment, 19th Company R.A.M.C.

The undermentioned Officers relinquish their Commissions and retain the rank of Capt.—H. P. Aubrey, G. G. Thompson, F. H. Fuller, P. J. Watkin, W. P. H. Munden, H. W. Drew, J. A. B. Hammond, E. Coleman.

Temp. Capt. A. H. Spicer relinquishes his commission and is granted the rank of Major.

Temp. Lieut. R. M. Rendell relinquishes his commission and retains the rank of Lieut.

Civil.

L. E. V. Clayton, M.D., B.S., has been appointed Certifying Surgeon under the Factory and Workshops Acts for the Clevedon Division of Somerset.

Honours.

D.S.C.

The Distinguished Service Cross has been conferred upon Surg.-Sub-Lieut. A. A. Orman, R.N.V.R., for services with the destroyers of the Grand Fleet Flotillas between July 1st and Nov. 11th, 1918.

Bar to M.C.

Major J. La F. Lauder, D.S.O., M.C.

M.C.

Capt. H. P. Whitworth, R.A.M.C.

Territorial Force Decoration.

The King has conferred the Territorial Decoration upon the undermentioned Officers.—Temp. Lieut.-Col. W. Hind, Major A. Thomas, Major J. Wallace.

Mentioned in Despatches.

The following Officers have been mentioned by General F.R. the Earl of Cavan, Commander-in-Chief of the British Force in Italy, dated Oct 26th, 1918:—

Temp. Capt. (Act. Major) R. H. Lucas M.C., A.M.S.
" " " " A. A. Miller, M.D., R.A.M.C., 24th C.C.S.

Acute Appendicitis.

CLINICAL LECTURE BY R. P. ROWLANDS.

Gentlemen,—Every year about 2,000 deaths in England and Wales are certified to be due to appendicitis. A great many more are due to the numerous complications of this treacherous disease, without the primary cause being recognised or certified. This waste of life is all the more deplorable because the victims of the disease are mostly *young* people, who are otherwise healthy and either on the threshold or in the prime of useful lives, and because timely operation would save the great majority. I have brought two patients to show you.

Case 1.—This man developed acute appendicitis six weeks before admission, and has been ill ever since. When at last he came in, there was a large abscess behind the cæcum. The abscess was opened and the appendix was removed a fortnight ago through a gridiron incision. A short tube with a wick of gauze was used for two days. There were signs that the abscess had at one time drained into the cæcum, relieving the patient for a time. You see that his wound is not quite healed yet, and it will be some weeks before he will be fit for work.

Because of delay, the best and quickest result was not obtainable in this case. He is not likely to develop a hernia although drainage had to be adopted. The valvular gridiron incision, made well up and out, is very rarely followed by hernia, even when a tube has to be used, and in this respect it contrasts very favourably with any form of vertical incision. It has been urged that it does not give enough room to work, but plenty of room is obtained by always carrying the incision in the deep muscles inwards for at least an inch into the rectus sheath. If necessary the deep aponeurosis in front of the rectus can be divided vertically upwards or downwards to allow still more room, without weakening the abdominal wall.

As a contrast, I shall briefly tell you of a recent case in which the ideal treatment was practicable.

Case 2.—A young lady medical student went to a dance in the evening, and at 2 the next morning she woke up with violent pain in the abdomen, with frequent vomiting, which kept her awake for the rest of the night. Her brother, an old Guy's man, took a four-hour journey to see her, then diagnosing appendicitis, and knowing the value of early operation he asked me to see her at 7 p.m. the same day. The abdomen was then rigid and tender over the right iliac fossa. At 9 p.m. the inflamed appendix was removed, and the patient made a good recovery. She was out of bed to tea on the fourth day, had her stitches removed on the sixth, had a bath on the seventh, and took a long train journey home on the thirteenth day.

The timing of the after-treatment is of great importance, making recovery more complete as well as more quick. The moral of the patient is maintained and even stimulated instead of depressed. The muscles do not waste and constipation is avoided. Above all, the circulation is maintained in its normal condition, so that thrombosis in the right auricular appendage with secondary pulmonary embolism is avoided.

Case 3.—The next case, that of a middle-aged man, is very similar to Case 1, but the abscess was much smaller. All the pus was carefully mopped away and all bleeding could be stopped, so that drainage was not required. The operation was a fortnight ago and the man has been walking about for ten days. He was very pale and exhausted, with a temperature of 95°, when he came in a month after the onset of appendicitis.

Case 4.—I am unable to show you this patient, because he has gone home well a fortnight after the operation. He was a boy aged six years, who was said to have had attacks of pain in the abdomen, with vomiting and fever, about every three months, and lasting about twenty-four hours. On February 23rd a similar attack developed with a temperature of 102°, and the pain became localised in the right iliac region. When I saw him on the 14th he was flushed, his tongue was furred, and he looked fairly ill. Abdominal influenza had been considered, but he had been admitted for observation. I think some of you were a little surprised when I said I should operate at once. The inflammation was fortunately limited to the appendix, which was distended and might have perforated at any time. I advise you to be very sceptical of the diagnosis of abdominal influenza; it has led to serious delay in many cases.

Symptoms and Signs.

Often there is a history of *bilious attacks* with abdominal pain on and off from infancy and without severe headache or visual disturbances.

Pain is at first referred to the umbilicus, but in some instances it is in the left hypochondrium due to violent contractions of the stomach ; later, especially if local peritonitis develop, it settles in the right iliac or hypogastric regions.

Tenderness.—Superficial tenderness is usually at or near McBurney's point, but it is not of same value as deep tenderness, which is elicited by pressure upon the inflamed appendix. This latter by no means always rests near McBurney's point, but commonly lies behind the ascending colon, on the right side of the pelvis, or in the hollow of the sacrum, often out of reach of a finger in the rectum or vagina.

It sometimes lies just internal to the anterior superior spine or near Poupart's ligament; occasionally it is near the duodenum and gall bladder. It is important to seek the appendix in these occasional haunts before deciding that there is no local deep tenderness.

Rigidity of the abdominal wall, especially of the right rectus and right oblique muscles, is a valuable sign.

Nausea and *Vomiting* are common in the early stages, and when the inflammation is spreading.

Swelling.—Either the inflamed appendix or more often an abscess may be felt in the right iliac fossa, right loin, or pelvis on bimanual examination.

The Temperature is usually raised, but by no means invariably. In some cases it may remain normal or even subnormal throughout.

The Pulse is generally quick, and a quickening pulse is more constant and significant than fever. The face is usually flushed and the tongue furred.

Insomnia from pain, uneasiness and toxæmia are common.

Constipation is usual, due to partial paralysis of peristalsis, but in some cases diarrhœa is marked owing to irritation of the colon, especially the pelvic colon by spreading inflammation.

Painful and frequent micturition are often troublesome when the appendix is in the pelvis. Sometimes retention of urine occurs. The association of diarrhœa with frequent and painful micturition generally indicates a pelvic appendicitis. The symptoms often subside owing to relief of tension in the appendix after perforation. This lull in the storm is very misleading and has led to dangerous delay in many cases. Abscess or peritonitis frequently follows and rapidly causes recurrence of symptoms.

Diagnosis.—Diseases which may be mistaken for appendicitis may be divided into two classes —(1) those diseases in which a mistaken diagnosis of appendicitis leads to an operation which proves to be unnecessary or even dangerous; (2) those in which a mistake is not serious because the condition present requires immediate operation in order to save life.

(1.) Under class (1) may be mentioned pneumonia or pleurisy on the right side, gastritis, gastro-enteritis from food poisoning, influenza of the abdominal type, pyelitis of the right kidney, especially that due to bacilluria.

The pain of pleurisy often radiates along the course of the lower intercostal nerves, and may be associated with rigidity of the abdominal wall, but careful examination of the chest generally reveals some dulness, deficient air entry or crepitations. Gastritis and gastro-enteritis do not lead to deep tenderness limited to the appendix. Pyelitis usually causes albuminuria

or pyuria. With influenza, the symptoms are not often limited to the abdomen, and there are no definite local signs over the appendix.

(2). Under class (2) may be mentioned perforated gastric or duodenal ulcer, suppuration of the gall-bladder, intestinal obstruction, inflammation of Meckel's diverticulum, acute pancreatitis, ruptured tubal gestation or pyosalpinx and twisted ovarian cyst. All these demand operation, but it is useful to make an accurate diagnosis if possible in order to select the best incision, to give a prognosis, and to make the best preparations. With perforation of a gastric or duodenal ulcer the onset is often more abrupt and severe and the initial severe pain and rigidity are usually in the epigastrium, rapidly followed by general rigidity of the abdomen.

With suppuration of the gall-bladder deep inspiration causes severe pain in the right hypochondrium, and there are usually dulness, tumour, and rigidity in that area.

With intestinal obstruction the temperature is usually subnormal, and repeated enemata fail to act satisfactorily. Rupture of a tubal pregnancy causes increasing anæmia with increasing swelling of the lower abdomen with subnormal temperature. Menorrhagia is usually present, and other signs and symptoms suggestive of early pregnancy. Twisted ovarian cyst is indicated by a defintie spherical movable tumour, which becomes more evident on bimanual examination under the anæsthetic.

As already indicated an operation as soon as possible is the best treatment for all these conditions, so that failure to make an exact diagnosis before operation is not serious. The most important is to decide for or against operation without delay.

Treatment.—I firmly believe it is wise for a good surgeon to operate whenever practicable *as soon as the diagnosis of acute appendicitis is made or strongly suspected, and the sooner the better.*

This is the best way to avoid dangerous and troublesome complications, and it is to be remembered that appendicitis is dangerous only when the infection is allowed to spread beyond the appendix, and to give rise to serious complications which must take some time to develop, and are therefore preventable.

Early operation saves the patient a great deal of pain, misery, time, and money, and relieves the medical attendant and relations of much anxiety. That it saves time and money is clear for if the patient gets over the attack he will have to lie up again during the operation, deferred until the interval; in this way the time of disablement and the expense are usually more than doubled. If suppuration develops, and an operation becomes absolutely necessary late in the attack in spite of conservative treatment, the patient may be laid up for weeks or even months. After recovery from an attack a patient often declines an interval operation and may develop another and perhaps a fatal attack.

In the early stage, especially in the first attack, the operation is nearly always easy, because adhesions are few or soft, and it is nearly, if not quite, as safe as an "interval" operation. On the other hand, no one can foretell the end of any attack of appendicitis under conservative treatment. No disease is more treacherous, for what may appear to be a mild attack frequently ends in perforative peritonitis or death. No one can say what is going on in the appendix or peritoneum until the abdomen is opened, for it is common upon exploration for slight symptoms to find a tense gangrenous appendix. The lull that often follows perforation is particularly deceptive, free pus being found sometimes in a supple abdomen, especially in children.

Nothing but early operation can remove the cause or set a limit to the spread of infection.

Various authorities give the mortality of appendicitis under medical treatment as from 10 to 14 per cent. This is capable of reduction below 1 per cent. by operating at the earliest possible moment. I have not lost a single patient operated upon within thirty-six hours; and, as shown by Dr. Mutch,* there were no deaths in the operations of many surgeons within the same interval at Guy's Hospital during the four years 1906—1909.

The mortality of my operations for acute appendicitis always undertaken as soon as I see the patients, but often very late in the attacks, especially in hospital practice, is under 3 per cent., although I have refused to operate in only one case, the patient being then moribund and dying within an hour.

In a few cases there is a little suppuration in the parietal wound, unless care is taken to protect it before dealing with the inflamed appendix and peritoneal effusion.

In a good many cases perforation of a pyloric or duodenal ulcer, inflammation of Meckel's diverticulum, suppuration of the gall-bladder, intestinal obstruction, and ruptured tubal fœtation have been mistaken for appendicitis, and the resulting delay in treatment under the conservative regime has usually been serious. Early exploration enables the surgeon to discover his error and to treat these grave conditions while they are in a hopeful stage. Although a mistake in diagnosis is occasionally made, the abdomen is rarely opened for a supposed appendicitis without revealing some other acute disease calling for immediate surgical treatment. A blank laparotomy is better than overlooking early peritonitis. It is particularly important to remember the possibility of mistaking bacillus coli infections, especially of the right kidney, for appendicitis. The pyelitis of pregnancy is also important to bear in mind.

If a competent surgeon is not available it is better to adopt the Ochsner conservative treatment and to keep the patient at absolute rest on rectal salines with nothing by the mouth until the symptoms are abating. Above all no purgatives should be given. An operation must be undertaken if signs of localised abscess or peritonitis develop.

Serious Complications which can be avoided by Early Operation.

Spreading Peritonitis.—Frequently during an early operation, a gangrenous, distended, but still shiny, appendix is discovered ready to perforate at any moment. No one can say, with any pretence of accuracy, what the condition of the appendix may be until the abdomen is opened, and to wait is bound to be disastrous in many cases. Although the appendix may perforate within twenty-four hours or less it is rare to find diffuse peritonitis at that time. A local collection of sero-pus near the appendix or in the pelvis is infinitely more common. At first the pus is not limited by any adhesions, but only by gravity and the elastic pressure of the flatulent intestines, especially the cæcum. The effusion increases more or less rapidly according to the virulence of the infection and the reaction of the peritoneum. Unlike the stomach, the appendix is too small to flood the peritoneum, therefore appendicular peritonitis is of the spreading or creeping type. Usually the extravasation from the perforated appendix is found in the right iliac fossa, often behind the cæcum. As the effusion increases it overflows into the pelvis, especially if the patient walks about. When the pelvis

* This invaluable paper is in the Guy's Hospital Reports, vol xlix., p. 107.

is full, unless limiting adhesions have formed, the fluid rises to the left iliac fossa, left loin and amongst the coils of small intestine. In very late cases the peritonitis may be general, pus being discovered above the spleen and liver. At any stage limiting adhesions may isolate a localised abscess, but with increasing tension this may burst and flood a large part of the peritoneum. Our aim should always be to operate before the appendix perforates and thus to avoid either localised or spreading infection of the peritoneum. When the peritoneum has become infected the sooner an operation is performed the better, for the early removal of the source of infection, the appendix, and the extravasation nearly always arrests the spread of the disease.

Localised Abscess.—It is much better to operate before an abscess can have time to develop. I am well aware that it is not always possible because patients often do not send for their doctor until an abscess has already formed. There are instances of subacute attacks in which patients continue to work until an abscess or peritonitis develops. The dangers of an appendicular abscess are chiefly due to its liability to rupture into the peritoneum, causing spreading peritonitis. Many of the cases of peritonitis are of this grave secondary type. During the operation for appendicular abscess it is often noticed how frail are the adhesions that separate the abscess from the abdominal cavity, so that any unusual exertion, or the natural increase of tension, may lead to rupture into the peritoneal cavity at any moment. In more fortunate cases the abscess may burst into the intestine, and the patient may often get well soon after this; but it is a mistake to think that such a patient is not liable to future attacks. An abscess may burst into the urinary organs, possibly leading to cystitis and ascending suppurative nephritis. An abscess may form in the pelvis and lead to permanent damage to the important structures placed there. Residual abscesses may form at some distance, such as subdiaphragmatic abscess, which is still attended by a high mortality.

Empyema and other Pulmonary Complications.—There is little room for doubt that infections of the lungs and pleura are mostly embolic, and that the liability to them increases with the duration of the appendicitis. It is a fact that these complications, and especially subdiaphragmatic abscess, are far less common in patients treated by early operation. It stands to reason that with the continued presence in the abdomen of an inflamed appendix with infected blood vessels in communication with the portal vein, portal pyæmia is much more likely to occur than if the appendix is removed at once. Moreover, the presence of a suppurating appendix is a constant risk of general blood poisoning.

Intestinal Complications.—Intestinal adhesions with secondary intestinal obstructions and also fæcal fistulæ are far more likely to develop in neglected cases. Moreover there is some evidence to show that chronic constipation in many cases dates from a severe attack of appendicitis, followed by contracting adhesions.

Hernia.—By operating very early the risk of hernia is greatly reduced, for the abdomen can be completely closed in the majority of cases without endangering the life of the patient. In this respect, these early cases are in striking contrast with those for which an operation has to be performed later for spreading peritonitis or large abscess, when it is necessary to drain the abdomen for a few days at least.

Vascular complications, such as thrombosis, pulmonary embolism, septicæmia, and pyæmia are apt to occur in neglected cases.

Late and Suppurative Cases.—It must be allowed that although an operation at the

earliest possible moment is the safest and best treatment for appendicitis, it is often impossible to get this done for various reasons. Poor patients often do not ask their doctor to see them until they are getting seriously ill, and have tried in vain all their homely remedies, more especially a variety of purgatives. A skilful surgeon may not be available, the diagnosis may be very doubtful, or a patient may at first refuse operation. But, if the advantages of early operation were properly appreciated by those concerned, it is certain that there would be less delay than there often is at the present.

In such cases, seen after the most favourable time for operation has been allowed to pass, it is a difficult matter to decide for or against immediate operation.

1. *If the signs and symptoms are subsiding*, it may seem wise to postpone the operation until about a fortnight after the attack; but it must be remembered that appendicitis is a treacherous disease which is liable to take a bad turn at any moment, and that the patient is never safe until the appendix is removed, so that if surgical aid is not likely to be available at short notice, it is safer to operate at the first opportunity. The risk of operation in such cases is small, whereas the risk of leaving alone is uncertain. Under more favourable circumstances, such as exist in the wards of a hospital, where an operation can be performed at any moment, the risk of waiting for the quiescent period is smaller, and may seem to be justified by the low mortality of the interval operation. But in some apparently mild cases in which this course is adopted an abscess develops at any time within about fifteen days of the onset of the attack, often after all danger is supposed to be over. Then an operation has to be undertaken under less favourable circumstances. The risks of complications and of death are increased, and the difficulty of removing the appendix is greater on account of denser adhesions between vital structures, and the presence of pus. Drainage is usually necessary, and a ventral hernia is apt to follow in a few cases.

In those cases in which an abscess would not otherwise develop I do not believe that an operation at any stage of the disease increases the danger. The risk of causing a localised peritonitis to become diffuse is a very small one if proper precautions be taken to prevent it. The same is true of infection and suppuration of the abdominal wall. It is assumed, of course, that the surgeon is experienced and skilful in abdominal surgery, for what may be a safe course for one surgeon may be dangerous to advise for another. In any case, waiting involves waste of time, money, and anxiety. For these reasons I believe it is wise to recommend operation without delay in all cases of appendicitis when the circumstances are favourable, and a capable and experienced surgeon is available for what may prove to be a difficult operation. I believe that a careful operation reduces the dangers of the disease at all stages. Every surgeon knows that it is practically impossible in many cases to estimate the gravity of the patient's peril before the abdomen is opened. The duration of the disease is of little value, although it has been relied upon. The symptoms and even the signs are often deceptive. A wise and conservative physician told me that he had come painfully and slowly to the conclusion that immediate operation is the best treatment for appendicitis, at whatever stage the patient is first seen. However, different opinions prevail concerning the treatment of cases in which the patient is not getting worse, or the disease seems to be subsiding.

2. *When the signs and symptoms are getting progressively worse or fail to subside in due*

course after three or four days, it is imperative to operate without delay in order to save life. It is important to mention some of the most reliable signs and symptoms which indicate that the patient is getting worse, and that an operation is urgently required to save life.

Signs and Symptoms.

1. Increasing rigidity, tenderness, and fixation of the abdominal wall. When these conditions are localised to the right iliac fossa, they usually indicate a localised abscess, but when they are spreading they indicate a spreading peritonitis.

2. Persistence of pain and vomiting.

3. Accelerating pulse-rate.

4. Rapidly rising or falling temperature, especially associated with shivering; these indicate a rapid spread of the disease, and often follow the discharge of pus into the peritoneal cavity.

5. Shifting dulness in the flanks, indicating the presence of free fluid in the abdomen, generally due to spreading peritonitis, although there may be free aseptic fluid complicating a local abscess.

6. The presence of a tender, dull swelling in the iliac fossa, loin, or pelvis, the latter being discovered by bimanual examination.

7. Leucocytosis, especially a rise in the proportion of polymorphonuclear cells.

These indicate localised abscess. When the abscess is unusually high the appendix is retrocæcal or the cæcum has failed to descend naturally. When it is situated in the pelvis the appendix is hanging over the brim. A pelvic abscess is often indicated by frequent and painful micturition, rectal tenesmus, and diarrhœa. It may not be possible to feel the localised swelling until the abdominal muscles are relaxed by an anæsthetic. The swelling may be resonant, especially in late cases, from the presence of gas in the abscess. It is foolish to wait for fluctuation, redness, or œdema before opening a localised abscess, because of the grave danger of peritoneal and vascular infection.

8. Rapid wasting.

9. Profuse sweating, often associated with rigors.

These indicate spreading infection and suppuration.

The peritonitis is getting grave when distension of the abdomen and tympanites begin; but operation should not be deferred so long. Sometimes patients are seen in a state of collapse and too ill for any operation. It is then wise to endeavour to revive them by warmth, continuous rectal or axillary infusion, and the injection of pituitary extract before undertaking an operation.

It may be repeated that an exploration is the only reliable means of ascertaining the nature and extent of the abdominal disease, the signs and symptoms being notoriously inadequate.

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Scabies and Pediculosis Corporis.

(Continued.)

By H. W. BARBER.

The secondary lesions of chronic pediculosis may be classified as follows :—

(1) *Linear scratch marks* or excoriations, which from secondary pyogenic infection may produce one variety of so-called "impetigo."

(2) "*Boils*" formed in certain persons at the sites of the original bites.

(3) *Circular, encrusted ecthymatous lesions*, also often termed "impetigo," which are formed from (2).

(4) *Oblong or rectangular ecthymatous lesions*, resulting from (1) or (3).

(5) *Localised and generalised pigmentation.*

These may now be considered in detail.

(1) *Linear scratch marks.*—These are produced by vigorous scratching with the fingernails. They are seen at the sites of election of pediculosis to be later described, and their direction follows that in which a person instinctively scratches himself in different situations. Thus, on the shoulders they run upwards and slightly inwards, in the posterior axillary regions nearly horizontally outwards, on the buttocks upwards and outwards, and on the thighs and legs vertically upwards. In uncomplicated cases the excoriations are merely dried blood-crusts, but secondary pyogenic infection may take place with the production of one form of "impetigo," and ecthyma—usually of the superficial type—may result.

(2) "*Boils.*"—If the term "boil" be confined to a deep inflammation of a pilo-sebaceous follicle, caused by the staphylococcus aureus, then the characteristic pustular lesions of pediculosis corporis are not boils in the true sense of the word. For the pediculosis "boil" is an infected bite, and is not a folliculitis. It is necessary to insist on this, as the fact has been disputed by some dermatologists. Ordinary boils may be met with in pediculosis, usually from a follicular infection of the surrounding skin by the pus from a true pediculous lesion, but the latter differs from them both in development and in appearance. According to Schjödte, Tilbury Fox, and others, the louse, when biting, first inserts its labium into a sweat-pore, so that it is probable that the pediculous "boil" arises around a sweat duct.

The lesion first appears as an indurated red or bluish halo around the original bite, and in the centre a minute yellowish-white vesicle, rapidly drying to form a crust, is seen. In the more superficial lesions a small quantity of pus exudes on pressure from the central vesicle or crust, whereas on squeezing the deeper "boils," which are surrounded by considerable induration, a quantity of fluid sanguineous pus is forcibly ejected from what is evidently a bottle-shaped cavity. If the lesions are treated early enough by evacuating the pus and painting with weak tincture of iodine, they usually involute without progressing further, but, if not interfered with, they are apt to give rise to (3). In any case the pediculous boil, on healing, leaves a *pigmented* scar, which is quite characteristic.

(3) *Circular, encrusted ecthyma.*—These lesions consist of ulcers of various depth covered by brownish crusts. They arise from the "boils" by centrifugal extension of infection, presumably by the lymphatics, from the central cavity, and all stages may be met with between the two types of lesions.

(4) *Oblong or rectangular ecthyma* ("Linear Impetigo").—The superficial type of this lesion may arise from secondary infection of the linear

scratch-marks. But the variety which is pathognomic of louse infection is a gutter-shaped ulcer, covered by a brown crust and of considerable depth. Its outline varies with the stage of its development, which probably proceeds from the longitudinal digital excavation of one of the circular ecthymatous lesions described above, and in a severe case of pediculosis all the intermediate stages between circular and rectangular ecthyma can be demonstrated. Both forms leave, when healed, pigmented scars. As pointed out by MacCormac, a streptococcus of the *faecalis* type could usually be cultivated from these ecthymatous lesions among soldiers in France.

(5) *Pigmentation.*—This is one of the best known and most interesting secondary results of chronic pediculosis corporis, but, just as some men may remain lousy for months without ever developing "boils" or ecthyma, so the pigmentation differs greatly in intensity in different individuals. As might be expected, it is always most marked in dark persons, and in them it may be so deep as to simulate that seen in the later stages of Addison's disease. In some cases the pigmentation develops very rapidly, but usually the severer forms occur in men who have harboured lice over a long period. Although in a well-marked case the skin of the trunk and limbs is diffusely discoloured, the pigmentation is always most evident at the sites of election of pediculosis to be presently described, and the scars of healed "boils" and ecthymatous lesions show the deepest tint of all.

Thibierge has stated, and Darier confirms his observation, that pigmentation of the mucous membrane of the mouth may be seen in chronic cases of pediculosis, but I have never satisfied myself as to its occurrence. But there is no doubt that the pigmentation of pediculosis is the result of a reaction of the host to a toxin injected by the louse, and that this reaction is most intense at the sites of injection of the toxin, which, however, if absorbed in sufficient quantity, may lead to diffuse generalised pigmentation of nearly the whole skin.

Distribution.—This is just as characteristic as that of scabies, and must depend on the fact that the louse prefers to feed in certain situations. The sites most frequently involved are *the scapular regions and the posterior axillary folds, a diamond-shaped area over the sacrum, the upper part of the buttocks, outer side of the thighs, the groins*, and *the skin between the knees and ankles*, particularly on the outer surface. In a well-marked case the skin in these situations is usually pigmented, and the linear excoriations, the characteristic "boils," and the ecthymatous lesions form a very striking picture. I would particularly wish to emphasise the importance of the diamond-shaped area in the sacral region.

At this point the main differential points in the diagnosis of scabies and pediculosis may be summed up as follows:—

Scabies.

Localisation.—Hands, wrists, elbows, anterior axillary folds, umbilicus, abdomen, lower half of buttocks, penis, knees, and ankles.

Type of Lesions.—Burrows vesicles, small superficial crusts, papules, pustules, and a specific erection of the pilo-sebaceous follicles. Scratch marks are represented by minute blood crusts at the apices of the erected follicles.

Pediculosis.

Localisation.—Posterior axillary folds, shoulders, sacral region, upper half of buttocks, groins, outer part of thighs, and skin between knees and ankles.

Type of Lesions.—Deep "boils," circular and elongated crusted ecthyma, pigmentation. Scratch-marks are linear. Lesions, on the whole, larger and more isolated than in scabies.

Treatment.

Scabies.—In the British army the methods employed for the treatment of scabies differed in different units, and some of them were manifestly unsatisfactory. It would, however, be unprofitable to discuss the subject now, but it is remarkable that no uniform method was adopted for the army as a whole during over four years of warfare. Unfortunately many cases were treated for weeks for "impetigo," or "boils," the underlying parasitic infection being unrecognised, and, owing to the prevalence of the "seborrhœic state," secondary eczematisation and severe pyogenic infection frequently complicated the disease, and delayed convalescence.

In civilian practice the treatment to be adopted will depend largely on whether it can be carried out under the direct supervision of the medical attendant, or whether the patients be left to treat themselves in their own homes. Whatever method be chosen, the main objects in view are to open up the burrows and to destroy the acarus and its eggs. The first may be achieved by vigorous friction and scrubbing with soap in a hot bath, the latter by the thorough application of antiparasitic substances, of which sulphur, beta-naphthol, balsam of Peru, storax, and tar preparations are the most usually employed.

The classical "frotte" of the St. Louis hospital in Paris is a very satisfactory and rapid method of treating *uncomplicated* scabies, and was generally practised in the French Army. As it is the method of choice when dealing with epidemics in large institutions or even in families, providing that it be carried out under supervision, a brief description of the technique may be given :—

1. The whole body, except the face, is well rubbed with green soap for twenty minutes, special attention being paid to the regions chiefly affected in scabies.

2. A hot bath is then taken, in which the patient continues to rub himself for half an hour or more.

3. The body is dried, and the hands and wrists again rubbed with a rough cloth and soapy water to ensure the opening of burrows and vesicles.

4. An ointment, consisting of sublimated sulphur 20 per cent., neutral potassium carbonate 10 per cent. in lard, is then rubbed into the skin of the whole body, excepting the head and face, for fifteen minutes. Clean pyjamas or underclothing are donned, and in the evening the ointment is reapplied to the selected sites.

5. The next day a warm bath, lasting for fifteen minutes, is taken. Afterwards a dusting powder is freely applied, and the patient is given his own clothes, which by this time have been washed and disinfected.

It is essential that the friction with soap and the application of the ointment be carried out under careful supervision. It will be observed that the treatment is completed in twenty-four hours, and statistics show that a cure results in about 95 per cent. of cases, but very young children, pregnant women, and people with delicate skins should not be submitted to so vigorous a method.

For the treatment of Out-Patients an ointment should be given, and the patient be instructed to begin the treatment by thoroughly washing himself, if possible, in a bath or tub, with soap and hot water along the lines already indicated. He should then apply the ointment all over, particularly to the sites of election of the disease, and this should be repeated morning and evening for the following three or four days, at the end of which time another bath is taken, and a complete change of underclothing and bedlinen made. It is a good plan to re-

commend that the same underclothing be worn night and day during the period of treatment, and special care should be taken that the bed-linen should be thoroughly washed and disinfected.

The choice of ointment will depend on the nature of the case. For ordinary cases, uncomplicated by much secondary eczematisation or pyogenic infection, the Ung. Sulphuris, B.P., is simple and effective, but it should not be employed for more than a few days, and in seborrhœic persons it is always liable to provoke a secondary dermatitis. As substitutes for sulphur, storax (Styrax præp, 8 parts, Adeps præp. 30 parts), or balsam of Peru, or beta-naphthol may be used, and the following formulæ are recommend :—R. Naphthol. 15 parts, Sapon. virid. 50 parts, Cretæ præp. 10 parts, Adipis 100 parts. R. Balsami Peruv. 15 parts, Styracis liquid 20 parts, Cretæ præp. 20 parts, Adipis or Vaselini 45 parts. To these Ol. lavandulæ or other essential oils may be added in private practice.

Should a case be already complicated by severe eczematisation, one of the above preparations diluted with equal parts of Ung. Zinci may be used for several days, and it will usually be found that, with the cure of the scabies, the dermatitis rapidly subsides. But such cases require watching, for experience has shown that they are liable to relapse, although apparently cured. Severe cases of secondary seborrhœic eczema, and those with furunculosis and lymphangitis, should be freely purged and given large doses of alkalies. It must always be remembered that itching may continue, particularly in those who have been treated with sulphur ointment, after the scabies is actually cured, and in such cases zinc ointment or Lassar's paste should be ordered. A patient should not be considered cured until all itching and irritation has been absent for at least a week.

Pediculosis corporis.—The essentials of treatment are to destroy the lice and their ova in the clothes by immersing the latter in boiling water or by subjecting them to the heat of an oven (160°—180° F.), and to destroy the ova in the hair of the pubis, axillæ, perineum, and elsewhere. In civilian practice the disease is peculiarly common in old people, and for such it is advisable to prescribe an ointment containing staves-acre (Ung. Staphisagriæ, B.P.) to be applied freely at night time, or one containing five parts of carbolic acid to a hundred parts of vaseline.

Boils should be treated by evacuating the pus and painting with a weak solution of iodine in spirit. Patients with ecthyma should take repeated alkaline baths, and apply a mercurial ointment to the sores after removal of the crusts. An ointment, which was found very serviceable in treating such cases among soldiers, is as follows:—R. Sulph. præcip., Acid. Salicylici aa gr. x. Ung. Hyd. Ox. Flav. ad oz. i.

Guy's Hospital Dental Society.

The twentieth annual dinner of the Society will be held on Saturday, May 10th, at the Connaught Rooms, Great Queen Street, W.C. 2, at 6.30 p.m. Mr. Montague F. Hopson, the President of the Society, will occupy the chair.

As this will be the first dinner of the Society to be held since February, 1914, it will partake very much of the nature of a great reunion of the past and present dental students of the Hospital, and it is hoped, therefore, that every old Guy's man will make a great endeavour to attend.

The Dental School Buildings will be open during the afternoon, when it is hoped that some clinical cases of interest will be shown.

The price of the ticket will be 12s. 6d. (exclusive of wine), application for which should be made to Mr. F. Bocquet Bull, the hon. dinner secretary, at 24, St. Thomas's Street, S.E.1.

The next meeting of the Society will take place in the Anatomical Theatre on Friday, April 11th, at 8 p.m. Papers will be read by Mr. F. N. Doubleday and Mr. F. Bocquet Bull. Mr. Hopson will occupy the chair.

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *in any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

Dear Sir,—I am writing to express my warm appreciation of the very kindly and generous manner in which you have dealt with my "dossier." It would be difficult for me to exaggerate the amount of happiness I have derived from my work at Guy's, and how much I owe to the intimate association with so many young and able men. They have been a constant stimulus and have filled me with a keen interest in their future careers. They have fully justified my hopes, and it is generally recognised that the traditions and reputation of our hospital could not be in better hands than theirs. —I am, dear Sir, yours sincerely,

W. ARBUTHNOT LANE.

21, Cavendish Square, W.
24th March, 1919.

Sir,—Your note in "Passim" in the last Gazette and the letter from Mr. Layton which gave rise to it prompt me to let your readers know that there is in existence the Auxiliary Royal Army Medical Corps Funds, the object of which is "to afford relief to those orphans of commissioned officers of the Auxiliary R.A.M.C. and the children of those totally disabled who may be left under circumstances of distress; or who may be enabled by an addition to their income to procure a better education than their means would otherwise admit"; and "to give pecuniary assistance in cases of distress to the widows and orphans of the rank and file of the Auxiliary R.A.M.C."

The Auxiliary branches of the R.A.M.C. are the Special Reserve, Territorial Force and New Armies. There is a similar fund for widows and orphans of the Regular R.A.M.C.

Every possible means is taken to let it be known that the Auxiliary Fund exists, and I hope that all who need help apply to it. If this is so, we learn that by far the greater number of the Auxiliary R.A.M.C. who have been killed were unmarried.

The members of the R.A.M.C. all over the world have subscribed most nobly to these Funds, and the Committee are in a position to consider very sympathetically all applications. They should be addressed to me at the offices of the Funds, 11, Chandos Street, Cavendish Square, W., 1.—Yours faithfully,

WILLIAM HALE WHITE,
Hon. Sec.,
Aux. R.A.M.C. Funds

11, Chandos Street,
Cavendish Square, W. 1.
24th March, 1919.

Sir,—I think our memorial, that object which is to remind future generations of Guy's men and women and others, of those who gave their lives for humanity in the Great War, should be something designed and reserved for that special purpose, and should be placed in some conspicuous position in or about the Hospital, and it should bear for all to read the names of those whom we wish to keep remembered. Also it should be durable and permanent, and capable of removal and re-erection on another site if the necessity arose. The exact form the memorial should take and the site it should occupy must be left to a competent committee to decide.

The work should be given to the most capable artist that can be found, and we should be moving in the matter, for presently all the best artists will be fully occupied with war memorials.

The cost of such a memorial as I suggest would be considerable, but I believe it would enlist the general support of all the friends of Guy's, and if well carried out would be a worthy and proper memorial of our dead. The provision of a hostel in connection with the Medical School is well worth consideration. It is a business matter, and should be discussed by business men entirely from a business point of view. As a memorial it would not be permanent. There are many such expensive and in some cases unwise, schemes now being considered by memorial committees.—I am, Sir, Yours very faithfully,

J. H. GIBSON.

Aldershot,
19th March, 1919.

Dear Sir,—Our memorial is to perpetuate—to keep truly living—the great sacrifice which has been made by those who have fallen. For their friends neither stone, bronze nor lettering is wanted, but for those who come after, who cannot be expected to realise so intensely all that they gave and did, the memorial should be an inspiration taking their thoughts past the reality of war to the spirit of its sons.

War is mainly prosaic and commonplace, only redeemed by the wonderful devotion and spirit of those who wage it. Only through the emotions can we approach or appreciate this spirit, and, therefore, let us have a memorial which will arouse them by its beauty of form. In the average man and woman the material preponderates over the emotional, and a memorial with a practical bearing will fail in what should be its first object.

Mr. Layton's scheme is a noble one, the hostel is a worthy one, but I would plead that the first consideration should be something beautiful in form, an everlasting tribute and remembrance, and having no other object.—Yours faithfully,

"CAMBRAI."

28th March, 1919.

Guy's Hospital Ball.

Guy's last Annua Dance was held abou five years ago, and with the advent of Peace it was deemed a suitable opportunity to revive one of the most popular functions connected with the Hospital. The Resident appointed a committee, who in turn chose one of the best rooms in London, Princes' Restaurant in Piccadilly, for the 1919 Annual Dance. This was held on Friday, March 21st. It was decide that any profits should be applied to the Guy's War Memorial, and the committee was most fortunate in obtaining Lady Fripp's consent to act as hostess. Mrs. H. Cosmo Bonsor, Lady Perry, the wives of the other members of the staff, and the Matron kindly agreed to act as patronesses. Sir Alfred and Lady Fripp gave the committee invaluable assistance with the organising of the dance, and the committee takes this opportunity of thanking them for all they did. Another most important factor was the band, and this, in order to be in fashion had of necessity to be a "Jazz. The Illinois "Jazz Band" proved in every respect to be most satisfactory, and in no small way added to the success of the evening.

In all two hundred and fifty guests were present, amongst whom it was most pleasing to see Sir Arbuthnot and Lady Lane, more so when one noticed the number of dances in which Sir Arbuthnot actively took part; Dr. Herbert French, Mr. and Mrs. A. W. Ormond, Mrs. R. P. Rowlands, Mr. and Mrs. Philip Turner, Mr. and Mrs. Trethowan, Mrs. Chapple, Dr. King Brown and his daughter. Old Guy's men were well represented, and many a pre-war friendship was renewed with evident pleasure. Amongst others one noticed Dr. and Mrs. Mutch, Mr. and Mrs. C. P. Symonds, Mr. and Mrs. V. Glendining, Dr. Spon, who brought a party, Mr. and Mrs. Mullally, Mr. Slesinger, Dr. O. V. Payne, Dr. Morgan, Capt. Eric Taylor, Mr. C. S. L. Roberts, and Mr. L. S. Debenham. Last, but not least, present Guy's men nobly supported their Hospital, and it was most interesting how frequently junior men were quite unknown to the seniors owing to the few chances offered where these men become known, due to the absence of any hospital functions and the curtailing of lectures during the war.

In conclusion, a word of praise must be given to the committee for their unceasing efforts in selling the tickets and their assistance in the organising of the dance, and more so when it is shown that the Guy's War Memorial will benefit by £74.

Guy's Hospital Employees' Social Club.

Dear Sir,

The Committee of the above Club met on the 5th March and unanimously agreed to recommend to a General Meeting of Hospital Servants "To revive the Guy's Hospital Employees' Club," which has been suspended during the war.

Now that hostilities have ceased, we welcome back all employees who have been serving with the Forces, and invite everybody to co-operate in the reconstruction of the social side of Hospital life.

Would you kindly bring this to the notice of every member in your Department? There is no earthly reason why every employee should not become a member of the Club. It has a great future. It helps the various Departments to get into touch with one another and provides the missing link connecting the Departments of the Hospital and Medical School.

Football, Cricket, Swimming, and Rambling Clubs are being formed in connection with the above Club. Whist Drives, Concerts, and Socials will be held at various intervals throughout the year.

On Tuesday, April 8th, a General Meeting will be held in the Pathological Theatre at 6 p.m., followed by a Whist Drive at 7 p.m. Tea and light refreshments will be provided from 8.15 to 8.45. Whist Drive M.C.'s, Messrs. Curry and Beckwith. Admittance free; entrance free.

J. H. E. WINSTON,
A/Hon. Sec.

Change of Address.

Capt. F. W. Fawssett, from 54 General Hospital, B.E.F., to Drury House, High Street, Gorleston-on-Sea.

Capt. F. H. Fuller, M.C., R.A.M.C., from Linde, Bournemouth, to 28, Old Steine, Brighton.

J. Young, M.D., B.S., from 94, Stamford Hill, N., to Burfords, Bishops Stortford, Herts.

Capt. F. D. Annesley, R.A.M.C., M.C., 48, Lime Hill Road, Tunbridge Wells.

Capt. P. R. Boswell, M.C., R.A.M.C., from 149 Brigade, R.F.A., to 17 Casualty Clearing Station, B.E.F.

Dr. H. Elliot-Blake, Etser House, Beer, Devon.

Lieut. S. A. Withers, R.A.M.C., 22 Indian Base General Hospital, Mesopotamia, B.E.F.

H. C. Malleson, 30, Thurlow Road, Hampstead, N.W.3.

F. Holcombe Fuller, from Poole Road, Bournemouth, to 28, Old Steine, Brighton.

Surg.-Lieut. N. Barlow, R.N., Ravenswood, Stornoway, Isle of Lewis.

G. Maxted, M.D., F.R.C.S., from 2nd Lond. General Hospital, to 14, Thorpe Mansions, Norwich.

Capt. W. L. G. Davies, R.A.M.C., Mont Dore Convalescent Hospital, Bournemouth.

Capt. E. P. Minett, R.A.M.C., 6th London Field Ambulance, E.E.F., to c/o Royal Societies' Club (on demobilisation).

W. E. Levinson, 5, College Road, Brighton.

C. H. Laver, late Temp. Surg.-Lieut. R.N., from H.M.S. *Nimrod*, c/o G.P.O., to 20, Pitt St., Portobello.

Lancelot Bromley, M.Ch., F.R.C.S., from No. 39 C.C.S., to 61, Queen Anne Street, W.1.

Harry Lee, F.R.C.S., from No. 2 London General Hospital, to 6, Park Square, Leeds.

Capt. G. E. L. Simons, R.A.M.C. (S.R.), Officers Mess, Peschawar, N.W.F.P., India.

B. Burnside, late Surg., R.N., from R.N. Hospital, Chatham, to Craig Muir, Western Australia.

F. G. Lloyd, F.R.C.S., The Firs, Reedham, Norfolk.

Capt. Harold Chapple, R.A.M.C., to 18, Devonshire Street, W. 1 (on demobilisation).

F. H. Wallace, 5, Bampfylde Street, Exeter.

D. Allen, 7, Brunswick Drive, Harrogate.

F. Vicars, Cavendish Club, 119, Piccadilly, London, W.

Birth.

BAXTER.—On March 31st, 1919, at 17, The Crescent, Plymouth, the wife of Capt. C. W. Woolloton Baxter, Indian Medical Service. of a daughter.

Marriage.

ECCLES—WESTON.—On March 25th, 1919, at St. John's Church, Hove, by the Rev. Canon Flynn, Herbert Nisbet, Capt. R.A.M.C., second son of the late George Henry Eccles, Esq., of Plymouth; and Lilian, third daughter of Mr. and Mrs. Charles Weston, of Benglo, Hertford.

Death.

TANNER.—On March 8th, John Edward, infant son of Capt. and Mrs. W. E. Tanner.

G. P. L.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE WAR MEMORIAL FUND.

With this issue of the GAZETTE there is sent out an appeal to all students of the Medical and Dental Schools asking for their help in this question of the Memorial. No one will feel any doubt but that there should be such a Memorial—the debt is beyond all calculation—and no one will of his own choice omit his name from the list of subscribers. The occasion is unique and calls for a generosity in which the "lore of nicely calculated less or more" shall have no part. The number of present students who have already given donations is a mere handful, but now that a personal appeal is circulated, let the response be unanimous and generous. No sum is too small, so let no one hold back on that account.

It is suggested that a special Students' Composite Fund be started, its progress to be published in the GAZETTE. A splendid lead has been given by this set of Residents in the matter. They have decided to forego the usual "going-off night" dinner, and instead most generously have all agreed to devote the bulk of the Residents' Fund to the War Memorial. Such an excellent example should be worthily followed. The object of the Fund is such as commends itself spontaneously. Perhaps the absence of any time limit causes delay in sending subscriptions, if so, we may say that no time should be lost, because the Secretary hopes to pay all working expenses from the interest without drawing on the principal.

SELF-CONGRATULATION is a dangerous thing, but the remarkably good results in the recent Final Conjoint call for some note. In the first place it speaks volumes for the Visiting and Teaching Staffs, many of the latter having lately returned, after varying periods of absence, with increased vigour and inspiration. But the noteworthy thing is this, that men who have just been up are those who for the most part did their dressing and clerking in the Wards and O.-P. Departments when the Hospital was extremely short-handed. It has been their privilege to take a bigger share in the actual daily working of the Hospital than has fallen to any previous generation of dressers. At a time when a firm had two, or even only one, dresser, and when it was not unknown that a man would be down to "run the Front" five or six times a week, there were obvious drawbacks, which were at times irksome, but the outstanding advantage was that men were brought into closer contact both with their teachers and patients. This forms a good illustration in

favour of Dr. Shaw's plea for upholding "Apprenticeship Teaching." There have been no regular systematised courses of lectures in medicine and surgery, and they are seemingly not looked upon as necessary, though the clinical lecture has survived, and few will doubt that it has a real value.

Dr. Shaw, on his last round, pointed out that it was not a characteristic round, because the large gathering instead of the "firm" compelled a more didactic method of teaching. In the same way it may be that the coming increase of men in the wards will, to some extent, necessitate a return to the old plan, though it will be the conviction of many that a regular course of lectures is of less value than the same time spent in the O.-P.'s, more particularly the special departments.

The Council of British Ophthalmologists have issued a report protesting against the insufficient teaching and examination of medical students in diagnosis and treatment of diseases of the eye. And in support of this it is shown from an analysis of Universities all over the world that only in Great Britain is adequate knowledge of Eye diseases not considered essential. At the outset all students must view with suspicion any attempt to add to the burden of the qualifying exam. The spreading of Medicine and Surgery into branches and the increasing development of these branches adds greatly to the difficulties of the student. This tendency is steadily growing, and it may be that this is the first of a series of protests from specialists that insufficient instruction is given in their own particular subject. In some Universities the requirements are obviously inadequate, and we hope the ophthalmologists will be content with a more uniform treatment of their subject by all Universities. If a man, as in the Conjoint and London Examinations, requires a certificate of regular attendance at the Ophthalmic Clinic for three months, we fail to see the necessity for a separate test in ophthalmology; in any case it is a bad precedent.

The plea for a motor ambulance attached to Guy's, put forward in a letter signed by the President and Vice-President of the Residents, has our entire support. The proposal has been raised in these columns before, but never has the need been greater than it is now. The number of motor ambulances used by the army must run into thousands. It would be a gracious act if the War Office presented one of the newer ones to Guy's. We hear that Bart.'s have obtained an old German gun. The War Office may present Guy's with one—we have a museum of antiquities. If they offer an ambulance it would show just that touch of humanity and commonsense which is so much needed in modern governments. And the War Office could rest assured that no ambulance could be put to better purpose than one serving the "Borough" and Guy's. What control has the medical profession over the disposal of these ambulances, the judicial distribution of which would help to revolutionise general practice in this country?

We would like to draw the attention of all Guy's Fellows to the fact that Mr. Steward is a candidate for one of the vacancies on the Council of the Royal College of Surgeons. The election takes place in July. The death of Mr. Dunn has left Guy's with none of its active staff on the Council. It is, therefore, of the highest importance that a strong effort should be made to ensure Mr. Steward's election, and we hope that every Guy's Fellow will send in his vote without delay.

We have great pleasure in congratulating Dr. H. W. Barber on his election to the Staff with the appointment of Physician-in-Charge of the Skin Department.

Streatfeild Research Scholarship in Medicine and Surgery.

In accordance with the Trust founded by Mrs. Eliza Streatfeild for the promotion of Research in Medicine and Surgery, a Committee of the Royal College of Physicians of London and of the Royal College of Surgeons of England is proceeding to appoint a Streatfeild Research Scholar.

The emolument will probably be £250 per annum, and the tenure of the Scholarship three years, at the discretion of the Committee.

Applications, which should state the nature of the proposed research, the place where it will be carried out, and the status of the applicant, should be addressed to The Registrar, Royal College of Physicians, Pall Mall East, S.W. 1., and marked "Streatfeild Scholarship."

Royal College of Physicians,
April, 1919.

University of London.

University Chair of Anatomy tenable at Guy's Hospital Medical School.

The Senate invite applications for the University Chair of Anatomy tenable at Guy's Hospital Medical School, of which particulars are appended.

Applications, accompanied by the names of persons to whom reference may be made, should reach the Academic Registrar, University of London, South Kensington, London, S.W. 7, not later than first post on Saturday, 3rd May, 1919. Ten copies of all documents must be furnished. Testimonials are not required.

Candidates summoned for interview will probably be asked to attend at the University on Saturday morning, 17th May, 1919.

Under the University Regulations Boards of Advisors are not limited in their choice to the persons who have applied for the post (see University Calendar 1918—19, page 190).

E. C. PERRY,
4th April, 1919. Vice-Chancellor

Copy of Advertisement.

University of London.—The Senate invite applications for the University Chair of Anatomy tenable at Guy's Hospital Medical School. Salary £600 a year. Applications (10 copies) must be received not later than first post on 3rd May, 1919, by the Academic Registrar, University of London, South Kensington, S.W. 7, from whom further particulars may be obtained.

Title.

1. The full title of the holder of the Chair will be "Professor of Anatomy in the University of London." The Chair is attached to the Medical School of Guy's Hospital.

Tenure.

2. The appointment will date from the 1st September, 1919, and will be subject to the Statutes and Regulations of the University governing Professorships, and to the Regulations of Guy's Hospital Medical School; the holder to retire on attaining the age of 60 years. In the first place, however, the appointment may be made for a shorter period; but in the case of re-appointment, it would be without time limit up to the retiring age.

3. The appointment will be a whole-time appointment.

4. The commencing salary of the Chair will be £600 per annum, which sum will be supplemented by a contribution to the University

Federated Superannuation System. The Professor to be required to contribute 5 per cent. of his salary to the Scheme under the Federated Superannuation System, the University contributing at least a like amount. These contributions are made year by year until the Professor attains the age of 60 years.

Duties.

5. The Professor will be Head of the Department of Anatomy, and will be responsible for the organisation and general conduct of the Department. The Professor is an appointed Teacher and is ex-officio a member of the University Faculties of Medicine and Science. The attendance at meetings of the Boards and Faculties with which the Professor is connected is an important part of his work.

Nursing News.

On March 15th, 1919, Miss W. Venning, Sister of Lydia Ward since August, 1914, left the Hospital to take up the appointment of Matron of a new Convalescent Home to be opened shortly at Walton-on-the-Hill. On completion of her training in 1910, Miss Venning took up private nursing on the Staff of the Guy's Institution for six months, and was then appointed Sister at the Royal South Hants Hospital, Southampton, which post she held until February, 1913, when she returned to Guy's as Sister of the Preliminary Training School.

Miss E. Achurch, Sister of Cornelius Ward since April, 1915, was transferred to Lydia; Miss N. Brabson, Sister of Patience and Samaritan Wards since November, 1917, was transferred to Cornelius; Miss A. M. Plant, Night Sister since May, 1918, was transferred to Patience and Samaritan, and Miss A. M. Lithgow, A.R.R.C., who completed her training in 1915, and has since been on Active Service in France, was appointed Night Sister.

Miss D. Palmer-Hall, Assistant Home Sister since March, 1918, is taking charge of Stephen Ward, *pro tem.*, and Miss L. D. Wharton, who completed her training in December, 1918, has been appointed Second Home Sister.

Miss Ada Fricker, who has been Matron of the Government Hospital, Port of Spain, Trinidad, for the last ten years, returned to the Hospital as Holiday Sister, and took up her duties as Medical Night Sister on April 4th.

Appointments.

Medical School Appointments

April–June, 1919.

Dressers or Clerks in Special Departments:—

A. *Throats* (Mr. Mollison). *Orthopædics.*—Messrs. J. V. C. Braithwaite, G. P. Lindsay, R. B. P. Lansdown, W. W. Payne and *S. Rose.

B. *Throats* (Mr. Layton.)—*Genito-Urinary.*—Messrs. H. Ameen, M. F. Ismail and C. M. Probert.

C. *Children—Eyes* (Mr. Eason).—Messrs. W. F. Attwater, W. S. R. Thomas and N. V. Wadsworth.

D. *Skins—Nerves—Eyes* (Mr. Ormond).—Messrs. H. T. Le Vieux and D. J. O'Meara.

Obstetric Dressers.—Messrs. L. Burvill-Holmes, S. Cohen, L. Moss, T. W. Turner and G. Massie (Mr. Bellingham,Smith); E. C. Grey, M. A. R. Khalifa, H. A. A. Pargeter, B. M. Tonkin and G. H. Oriel (Mr. Chapple).

Dressers.—Messrs. E. J. Crisp, E. T. Lloyd, J. Totton, I. W. Arnovitch and A. Mikhail (Sir Alfred Fripp and Mr. Turner); R. M. Patterson, I. Rosenberg, J. Sullaiman, M. Hall and J. T. Jones (Mr. Steward and Mr. Hughes); P. Couacaud, K. J. H. Davies, T. Reed (April only) and E. F. Wilson (Mr. Fagge and Mr. Davies-Colley); F. W. Crook, E. E. D. Gray, W. Remington, I. B. McCann, P. L. Richardson and R. E. Williams (Mr. Rowlands and Mr. Bromley).

Medical Ward and Post-mortem Clerks.—Messrs. A. Mackenzie, S. Annecke, J. E. Fishburn, J. B. Gregor, and L. K. Watson (Dr. Shaw); M. Maizels, G. W. Elkington, O. T. Maclaren, B. Kessel and F. L. Rayner (Dr. Fawcett); W. D. Doherty, J. J. F. Rooney, F. Bekker, L. R. A. Wells and G. B. Kirkland (Dr. Beddard); M. Sidky, C. I. C. Gill, J. H. Burn, L. W. MacDevitt G. E. W. Felce and A. H. Shelswell (Dr. French).

Student Assistant in the Bacteriological Department.—Mr. S. Rose.

Student Demonstrator of Microscopical Pathology.—Mr. A. Mackenzie.

Assistant Surgeon's Clerk.—Mr. F. W. Widgery (Mr. Bromley).

*(May and June only).

R.A.M.C.

The following Officers relinquish their acting rank on ceasing to be specially employed.—Major (Acting Lieut.-Col.) H. Fulton, Capt. (Acting Lieut.-Col.) A. T. Falwasser.

Major M. C. Wetherell retires, receiving a gratuity on account of ill-health contracted on active service, and is granted the rank of Lieut.-Col.

Capt. T. B. Layton, D.S.O., to be Acting Major whilst specially employed.

Officers relinquishing their Commissions:—

Lieut.-Col. G. A. Wright, and is granted the rank of Lieut.-Col.

Temp. Capt. L. R. Broster is granted the rank of Major.

Capts. C. Aldis, L. D. Stamp, N. Garrard, W. A. Elwood, G. Birch, G. Wacher, A. Scott, J. D. Pearson, A. H. G. Burton, R. Fell, A. H. Turner, and are granted the rank of Capt.

Lieut. R. Tilbury is granted the rank of Lieut.

Special Reserve.

Capt. (Acting Major) G. Marshall relinquishes his acting rank on re-posting.

R.A.F.

Medical Branch.—To be Temp. Lieut.—J. Kyle.

Honours.

O.B.E.

Surg.-Lieut. Evelyn Dennis Scott, for valuable services at Queen Mary's R.N. Auxiliary Hospital, Southend-on-Sea.

Bar to M.C.

Temp. Major E. Biddle, M.C. Capt. (Acting Major) A. L. Shearwood, M.C.

M.C.

Temp. Capt. R. W. P. Jackson.

Change of Address.

Hedley Visick, The Wolds, College Road, Eastbourne.

H. O. Long, late Surg.-Lieut. R.N., from H.M.S. *Cleopatra* to c/o Dr. Green, The New House, Ross, Herefordshire.

H. T. Depree, from H.M. Hospital Ship *Berbice*, to 68. Portland Court, W. (Tel. Mayfair, 3240).

Maj. L. Price Harris, Granville Place, Portman Square, W.

Capt. A. Reeves, R.A.M.C., 6, Streatham Hill, S.W.2. (on demobilisation).

N. N. A. Houghton, 67, Bridhurst Rise, Croydon.

J. L. Percival, 17, Duke's Avenue, Muswell Hill, N. 10.

Maj. A. C. Hancock, M.C., R.A.M.C., from Bright Ward, Guy's Hospital, to 10, Percival Terrace, Kemptown, Brighton.

Lieut. S. A. Withers, R.A.M.C., from 22, Indian Base General Hospital, to 25, Indian Base General Hospital.

Capt. W. D. Newland, R.A.M.C., "Elope" Force, North Russian Expeditionary Force.

Capt. W. E. Watson, R.A.M.C., 32, Casualty Clearing Hospital, Messina, Egyptian Expeditionary Force.

Surg.-Lieut. M. F. J. Hopson, R.N.V.R., 65, Northbrook Street, Newbury, Berks.

W. J. Vance, Studley House, Epping, Essex.

Correction.—We announced in last week's issue that Dr. Elliot-Blake had changed his address. We find that is incorrect, as he has resided at Estser House, Beer, for some years.

Papers by Guy's Men.

J. W. H. Eyre, M.D., F.R.S., and E. Cronin Lowe, Capt. N.Z.M.C.: Report upon the Autumn Influenza Epidemic (1918) as it affected the N.Z.E.F. in the United Kingdom.—*Lancet*, April 5th, 1919.

Capt. A. J. Eagleton, M.D., and another: Some points in the treatment of complicated influenza.—*Ibid.*

Capt. G. T. Wrench, M.D., B.S., R.A.M.C.: Studies in Ankylostomiasis: Nos. 1, 2, 3, *Ind. J. Med. Research*, Jan., 1919.

Discussion on Shock.—*Proc. Roy. Soc. Med.*, Feb., 1919: J. D. Malcolm, M.B., C.M., F.R.C.S., p. 9. Sir W. Arbuthnot Lane, Bt., M.S., F.R.C.S., p. 26.

Discussion on the teaching of Obstetrics and Gynæcology from the point of view of a General Practitioner: *Ibid, Sect. of Obst. & Gyn.*, J. D. Malcolm, p. 53.

H. H. Dale and P. P. Laidlaw: (1) A simple method of short circuiting the portal circulation. (2) Histamine shock.—*Journ. of Phys.*, Vol. lii., No. 5, March 25th, 1919.

Influenza.

CLINICAL LECTURE BY HERBERT FRENCH.

Gentlemen,—To-day the subject for discussion is Influenza. One cannot cover the whole ground in one hour, but we can deal with certain points in connection with the disease, particulary that type of it which is now raging all over the world.

Influenza, in the ordinary way, is a short febrile illness, of relatively little importance. The disease is always, more or less, with us, and there is a tendency to diagnose almost any kind of pyrexia as influenza. A celebrated physician has described influenza as the name given to any obscure febrile illness of short duration, by those who are "diagnostically destitute." That is not a bad description in ordinary times, but when things reached their present state, millions of people being down with it, and in all parts of the globe, "influenza" has temporarily become of gigantic importance, especially in view of the great number of deaths it has caused and still is causing.

Why should it be so different in type now from the relatively innocuous illness "influenza" has been during all the years that we have been growing up? History tells us why.

Records of the past show that most infective diseases exhibit big waves of waxing and waning virulence, these waves sometimes extending over long periods of ten, twenty, thirty or it may be fifty years. Microbial diseases which for years on end may be quite mild tend periodically to become unduly virulent. Scarlet fever is another example of this. Some of you do not think seriously of scarlet fever, because at the present time most of the patients get well; the mortality is low. Dr. Blades, an old Guy's man, died recently at the age of 80, and he very much impressed me with a description of what scarlet fever was like when he was a young man. He had been attending some scarlet fever patients, and carried the infection home. Within ten days his wife and three of his children were dead from scarlet fever; the percentage mortality was so high everywhere that it was indeed an infection to be dreaded. Since then the virulence of scarlet fever has become so much less that the risk of death from it is light, and many cases are so mild that the diagnosis is often missed altogether until the patient subsequently peels. I feel sure, however, that a time will come again when scarlet fever is once more very virulent, for almost all infective fevers show long-drawn-out waves of waxing and waning severity.

Just in the same way there have been periodical outbreaks of virulent influenza. Its severity in 1889—90—91 is well remembered by many of us, and that was the last time when it was extremely virulent. The period before that was early in the nineteenth century. At the present time we are experiencing one of these periodic flarings up, and it is world-wide and therefore probably not caused by war-conditions. In 1889 the acute epidemic started in Siberia or China, and spread westward until every country in Europe was affected. The present outburst began in Spain, and has been spoken of as Spanish Influenza; and it has spread to every Continent and to practically every nation, killing such vast numbers that the total deaths from it already run into many millions. This influenza has killed more persons than has the European war.

So virulent has been the present epidemic that at one time there were doubts as to whether it was really influenza or whether, on the other hand, it might not have been some new kind of plague. Pfeiffer's bacillus, however, has been recovered from such a large proportion of cases in different parts of England and in

different countries of the world by observers who have had the greatest skill in isolating and identifying these minute micro-organisms that there can, I think, be little doubt that the disease is really influenza in the main. In the mild cases, which have been the majority, the illness seems to have been influenza pure and simple; in the severe cases, on the other hand—and these are the cases that have attracted the greatest notice because of their extreme severity and high rate of mortality—it seems clearly established that there is always a double infection. The Influenza bacilli start the attack and are responsible for its epidemic distribution, but pneumococci or streptococci, or pneumo-bacilli, which may have been already latent in the patient's mucous membranes, seem to have their virulence so much increased by symbiosis with the Influenza bacilli that the actual influenza itself becomes entirely overshadowed by a virulent and generalised acute toxæmia or septicæmia due to pneumococci, streptococci, or pneumo-bacilli as the case may be. The importance of this double infection by the Influenza bacilli and virulent cocci was already familiar to us at Aldershot before the present epidemic started, for we had constantly met with sporadic cases, or even mildly epidemic cases of a very peculiar form of "pneumonia" which was characterised by the relative fewness of the abnormal physical signs, the great respiratory rapidity, the cyanosis, the high mortality and the very abundant expectoration which led to this type of case being differentiated off from other cases of pneumonia under the heading of "purulent bronchitis"; and it was thanks to Sir Alfred Keogh that Dr. Eyre was allowed to work with me in elucidating the bacteriology of these curious cases down at Aldershot, with the result that Dr. Eyre showed that their bacterial nature was one of influenzo-pneumococcal septicæmia. In similar cases of purulent bronchitis, occurring in epidemic form in and around Salisbury, Dr. Eyre found that the second micro-organism was not the pneumococcus, but the streptococcus, the condition there being one of influenzo-streptococcal septicæmia, and it is not unreasonable to suppose that besides pneumococci and streptococci yet other micro-organisms may produce this severe type of cases when they lead to septicæmic symptoms superimposed upon ordinary influenza. This double nature of their bacteriology was discovered by Dr. Eyre when there was no epidemic of influenza rife, and it was only as the result of careful bacteriological studies that these influenzo-pneumococcal and influenzo-streptococcal cases were shown to be entirely different to the ordinary pneumonia cases with which they had, up till that time, generally been grouped. There is now very strong reason to suppose that precisely the same bacteriology applies to the severe type of case that has been occurring throughout the world in the present epidemic. Whereas the milder cases appear to be influenza pure and simple, the severe cases are influenzo-pneumococcal or influenzo-streptococcal, and the fatal results are due rather to the acute pneumococcal or streptococcal toxæmia or septicæmia than to influenza proper.

At the same time respiratory symptoms have been predominant in most of the severe cases, with more or less evidence of lung consolidation, and it has become a general habit to speak of this severe type of influenzal case as "influenzal pneumonia," or as "influenza with lobar pneumonia." I want, however, to emphasise the view that, notwithstanding the predominance of lung signs and symptoms, the cases are not instances of true pneumonia in the ordinary sense, nor are the lung changes the only systemic lesions from which the patients suffer. In a great many cases there is acute tubal nephritis as well, and post-mortem findings show that hardly any organ in the body

remains free from damage, and even in those cases in which the lung signs attract the most attention I feel sure that, although pneumonia may be a convenient label to give them, one gets a false conception of what is really wrong with the patient unless one remembers that they are really suffering from influenzo-pneumococcal or influenzo-streptococcal generalised toxæmia, or actual septicæmia, and not from an infection confined to the lungs and respiratory passages.

It is perfectly true that in a great many cases there has been dulness of a whole lung lobe with bronchial breathing, crepitant râles, bronchophony and pectoriloquy over this lobe; in other words, precisely the physical signs one would expect if there were lobar pneumonia; and in the sense that a whole lobe of a lung, or more than one whole lobe may be consolidated, the patients do have actual "lobar" pneumonia; but the condition as seen in the post-mortem room is, in my experience—which extends to thousands of cases with hundreds of post-mortems—never one of true croupous pneumonia. One never sees typical red hepatization or typical grey hepatization in these cases in the post-mortem room. What one sees is a complexity of associated and mingled lesions, and I will try to indicate the kind of thing one meets with as a rule.

It is not easy to depict these because they are so variable in the degrees and extent to which the following various conditions may be mingled together, namely :—Broncho-pneumonia; œdema; extreme congestion; diffuse hæmorrhage, not solid; solid hæmorrhage; infarction ; multiple small areas of collapse ; massive collapse; formation of abscesses, generally small, but often multiple and aggregated; pleurisy; compression (by fluid); interstitial emphysema; bronchitis and peri-bronchitis;* and gangrene.

* Difficult to demonstrate macroscopically, but shown to be extensive microscopically.

One case may exhibit extreme congestion œdema, with disseminated non-confluent broncho-pneumonia, subpleural hæmorrhages, and angry-looking purulent pleuritic lymph.

The next may have complete consolidation of both lower lobes by confluent broncho-pneumonia without any pleurisy at all.

The next may have not lobar consolidation, but irregular masses which are more easily felt than seen, of deep crimson consolidation due to combined broncho-pneumonia, collapse, and hæmorrhage, scattered widely through all the lobes of both lungs, with or without acute pleurisy.

The next may have one entire lung apparently healthy, the upper lobe of the other pale and over-distended, and the remaining lower lobe heavy, nearly but often not totally airless, of a consistence to suggest spleen rather than liver, and of a dull, deep-slate colour externally, still further suggesting a post-mortem spleen.

The next may have broncho-pneumonia, more or less extensive in the lower lobes, with firmer wedge-shaped areas amongst the latter strongly suggestive of infarcts; whilst the upper lobes, free from broncho-pneumonia, may present from one to half a dozen or more typical infarcts, generally not large, of deep red colour, contrasting with the paler hue of the rest of the upper lobes.

In another case these infarcts may not be uniformly deep red, but pale, with crimson margins, due to the breaking down of the central parts into one or more incipient small abscesses.

Again, there may be no definite infarct, and yet over a more or less circumscribed region of one lobe, and often just below the pleura, as if they were originally in an infarct, one may see 20 or 30 pale yellow, slightly prominent areas, each of which turns out to be an incipient abscess or even a definite necrotic

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focus from which the contents can be washed out with a medium stream of water or readily expressed with the finger. It is from such superficial abscesses as these that perforation of both layers of pleura and consequent subcutaneous emphysema may arise; and if this is the sequence of events it is easy to understand why the development of subcutaneous emphysema generally prognosticates a fatal termination.

What the pathology of the infarcts is we cannot say with certainty.

Very possibly they are thrombotic and not embolic, in which case they point to severe changes in the vessel walls and perhaps in the blood itself. On the other hand, when one considers the frequency of purulent infection of the sphenoidal air cells, one feels that thrombosis of venules in the neighbourhood of the base of the skull, where they are difficult to demonstrate either clinically or post-mortem, is not an improbable event, leading, perhaps, to small, but virulent septic emboli of the lungs with infarction and the formation of abscesses in the infarcts.

Perhaps both thrombotic and embolic infarcts occur; in either case their occurrence, not by any means in all cases, but none the less in many, is a reminder that the vascular route of lung infection must not be forgotten. It seems highly probable that much of the lung mischief is due to direct invasion through the respiratory passages—from main bronchus to bronchioles and from the latter to the alveoli, bronchitis preceding broncho-pneumonia. But another route may be via the blood stream, thus accounting for the great severity of the infection and its high mortality.

Apart from actual infarcts, hæmorrhage into the deep lung tissue has been very common. Sometimes it is diffuse and difficult to demonstrate, owing to the already very deep crimson colour of the congested lung; but even then one can see it in the form of very dark, almost black, patches or ill-defined diffuse network, or a bigger localised mass which can be felt and which sinks in water.

The lower lobes have been affected very much more than the upper, though apical consolidation with confluent broncho-pneumonia is met with in a few instances.

With few exceptions the colour of the lower lobes has been deep crimson from extreme congestion, and very marked œdema of the lower lobes has been the rule, frothy blood-stained serous fluid pouring from the cut lungs when they are gently squeezed. This œdema is responsible for much of the increased weight of the lower lobes, and it occurs equally whether there is much broncho-pneumonia or little.

Although one has met with many cases with multiple small areas of necrosis or abscess formation, and many in which the lungs were pulped with ease by the hand, much in the same way as a decomposing spleen may be squeezed to pulp, one has seen no case so far of actual gangrene of the lung, and there has been no odour suggesting incipient gangrene. Perhaps this is due to the rapidity with which the disease progresses, so that patients have died before there has been time for true gangrene to develop.

I have met with no case of pneumothorax.

Pleurisy has been very variable in its incidence.

Quite a number of consecutive cases have exhibited acute pleurisy of the "lack-lustre" type with little or no fibrinous exudate and no free fluid, the acute pleurisy affecting one or both lower lobes, and much less often an upper lobe. Another group of cases have demonstrated no naked-eye evidence of pleurisy, although the intra-pulmonary lesions may be various and abundant. It has been exceptional to find much free fluid in the pleural cavity; one or two ounces of turbid blood-tinged fluid

are present in a fair number of cases, but a large effusion has been exceptional post-mortem. This is partly due to the recognition of fluid in the chest during life and its removal by aspiration, for fairly large pleuritic effusions have not been particularly uncommon in the wards. It is also partly due to the recovery of the whole of those cases in which the focalising effect of a copious effusion has been the patient's salvation.

The thin turbid fluid is clearly of the nature of an empyema, but it is not actual pus; it may become pus and need operation clinically, but we have not seen more than one or two cases of actual empyema in this disease post-mortem. I think the empyema cases tend to do well for the reason stated above.

Interstitial emphysema in the form of a fine melon-rind network beneath the pleuræ has occurred in several cases; the condition is doubtless the result of inflamed alveolar walls giving way under the stress of coughing efforts.

Acute bronchiolitis is nearly always present.

The histological changes in the lung tissues must be postponed for a subsequent communication. I would only say here that in many sections there is an appearance in and around the bronchioles and inside the alveoli which at first makes one think that the paraffin has been imperfectly removed from the tissue. At first it was thought that this was actually the cause of the appearance seen, but on further testing it seems that the appearance is due to a homogeneous structureless non-cellular exudate which fills the bronchioles and the peri-bronchiolar tissues and forms, as it were, a plastering round the inside of the alveoli. It is not fibrinous like the exudate of croupous pneumonia. Presumably it is an albuminous exudate, coagulated in the process of fixation, and it is very similar to that which can be seen in fatal cases of poisoning by chlorine gas.

This albuminous exudate throws much light on the nature of the dreaded cyanosis. If the oxygen in the alveoli has to traverse this albuminous layer in addition to the alveolar wall before it can get to the hæmoglobin of the blood, it is evident why there is such marked anoxæmia.

Let me next discuss briefly the points one relies on in giving a prognosis in a particular case. It is extraordinary how, in the present epidemic, instead of quite young persons or those beyond middle age being the most likely to die, the mortality has been greatest of all in strong healthy people between 20 and 35 years of age; in this respect the epidemic differs from that of 1889, 1890 and 1891, when it was the old and the very young who died for the most part. Roughly speaking the cases when one sees them in numbers at a time, as in the wards of a hospital, may be divided into two main groups: the mild and the severe. There are, of course, all intervening degrees, but in the main a case at any one time strikes one at once as being either of the quite mild type, or of the severe, simply from the general look of the case. If you ask me as to proportions, I would say that out of 1,000 cases 800 will be mild, the majority of them will run the usual course of influenza without material complication. The remaining 200 will be severe, and of these about 140 very severe; and out of these 140 one has had the mortification of losing about 80 in spite of everything one has attempted to do to save them. At the present time, fortunately, the virulence of the epidemic has lessened greatly, but both before and after Christmas the mortality rate was something like 8 per cent. of all the cases affected by the influenza, and when once it became obvious that a case belonged to the severe group he had only about an even chance of recovering. One might have thought that the pulse rate would have assisted one in gaug-

ing the prognosis, but this was seldom so. It was surprising how even in those who were obviously going to die, the pulse rate might be little, if any, above 100, and it might be only 90 and still quite good and regular.

Heart failure has not been prominent as a cause of death in these cases, except in so far as the pulse becomes running and rapid during the last few hours.

The respiration rate, on the other hand, helped one a good deal, for in the severe cases, whether the extent of consolidation was much or little, the respiration rate tended to be even more rapid than in that of ordinary lobar pneumonia. In ordinary pneumonia one expects the respiration rate to be 40 to 44, but it seldom exceeds 50. In these severe cases of influenza that we have been seeing of late, the respiration rate has often been 48 or 50, sometimes 55 or 60; and the most peculiar feature of this rapid respiration has been that it has seldom been associated with a complaint of breathlessness on the patient's part; he has not been orthopnœic; he has not been *dys*pnœic, —that is to say, he has had no *difficulty* in breathing; it has been a condition of rapid breathing without respiratory distress; a *tachy*pnœa rather than a dyspnœa; and, broadly speaking, one may say that the more rapid the respiration, the worse the prognosis at the moment, though it was not impossible for severe cases breathing over 50 to the minute to recover.

Most important of all, however, in gauging the prognosis in a particular case was the colour of the patient. So long as the complexion remained frankly red, one had no reason to be more than anxious about the case; when, however, into the redness there came some tinge of blue, then one knew that the prognosis had become very grave indeed. A few patients who had become cyanosed recovered, but the majority, once they developed the cyanosis, died, and in simply walking round the wards one could tell almost at a glance, and without examining the lungs as all, which were the worst cases merely by their colour.

To describe them solely as cyanotic gives but a very poor picture of the condition one has actually been seeing. I have never seen this type of cyanosis before, though it is similar to that which was seen in cases that were gassed at the Front. In the gassed cases, however, there was acute respiratory distress at the same time. whereas in these cyanosed influenzo-septicæmic cases the cyanosis has been associated with little or no distress.

I show you here three water-colour drawings of actual cases; the first presents the flushed red colour which one does not mind seeing, for, so long as it remains as red as this the prognosis is not unduly grave; incidentally the picture also shows the characteristic half-sleeping, droopy upper eyelid which nearly all these patients present.

The second painting shows the typical heliotrope cyanosis which may develop within 24 or 36 hours of the condition shown you in the first picture, and when once this tint presents itself the outlook is such that the patient is almost certainly going to die. He may survive for part of a day only or for several days, but out of 100 cases exhibiting this colour 99 will surely die.

The third painting I show you exhibits cyanosis of another type, and there may be any intervening degree of colouration of the face between those of the second and third pictures. It depends whether the patient is naturally pale or naturally rubicund whether there will be much or little of the heliotrope tint in his countenance, but the significance of the tint itself is the same in all, and I would say that the development of this colour, in the lips and ears especially, is the best guide of the badness of the prognosis in individual cases. So

long as whatever red colour there is in the lips or ears or elsewhere is a frank red, the case may do well; as soon, however, as the colour becomes such that one would have to mix some quantity of blue with one's red to match the hue, then has the prognosis passed over so much the more towards the grave side.

You might like me to touch upon the questoin of how to treat these cases.

I have tried autogenous vaccines and stock vaccines, anti-pneumococcal serum, antistreptococcal serum, normal horse serum, antiseptic inhalations, drugs of various kinds given by the mouth, including antiseptics such as creosote, and garlic preparations; I have attempted to produce fixation abscesses in the hope of focalising the generalised infection; injections of colloidal metals subcutaneously and intravenously; flavin injections intravenously, eusol injections intravenously and various other kinds of therapeutic measures, all without in the least influencing, so far as I could see, the course of the malady for the better. My strong impression has been that those cases that were put to bed early and were carefully nursed in a well-ventilated room did just as well, upon the whole, with simple nursing and attention as did other groups of cases in which any of the more complex lines of treatment were adopted. In other words, active treatment for the condition has so far been a failure. I am much in favour, however, of giving the patients as much water to drink as they can possibly take; it is generally not difficult to get them to take four pints of water a day, and if they will do this, I think they do a good deal better than if they are restricted as to their supply of water; and when drinking this quantity of water I do not think there is any need to worry if they take no food of any kind at all for the time being. So little, however, can be done by active treatment when the disease is once established that one cannot insist too much upon the essential need for adopting every conceivable method of prevention as infinitely preferable to attempts at active cure. If one regards these cases as highly infectious, the infection passing both from patient to patient direct, and also by air-borne particles sprayed from the mouth and nose in coughing and expectorating, with the possibility of spread by carrier cases after recent recovery, and also the possibility of spread by articles such as handkerchiefs, sheets, blankets, or the like contaminated by the patient's nasal or respiratory discharges, one has a very shrewd idea of the kind of prophylactic measures that should be undertaken when a particular case occurs in a community, and I need not go into all the details concerning segregation, isolation, screens, masks, overalls, disinfection of clothing, rooms, and so on.

I should, however, like to emphasise one point in prophylaxis which I do believe to be important, and that is in connection with nose and throat toilet.

There is much evidence to show that the upper respiratory passages, and particularly the naso-pharynx, is the primary focus of infection in at least a great many of these cases, and probably both the Influenza bacilli and the symbiotic organisms, whether pneumococci or streptococci, become absorbed primarily from this region, spread thence partly directly by the respiratory passages downwards to the lungs and partly via the blood stream with absorption into the engorged vessels of the mucosa in these parts. One point in favour of the naso-pharynx being of high importance is the fact that epistaxis has occurred in a very large proportion of all the influenza cases as an early symptom. In many such cases the nose-bleeding has been slight and may not have been reported by the patient, but in some the bleeding has been so severe that there has been even some difficulty in stopping it. So common has epistaxis been,

however, that one cannot help feeling that it points to turgid congestion of the nasal mucosa with breach of surface from superficial ulceration as a common feature of these cases.

Deafness, again, or at any rate considerable impairment of hearing has been a common early symptom suggesting also that there has been catarrh in the naso-pharynx spreading to, or interfering with, the Eustachian tube.

Whilst thirdly, and perhaps most important of all, there is almost certainly purulent infection of one or other of the larger air cell spaces that communicate with the nose. Out of 22 post-mortem examinations that I have made on cases of this kind, I have opened up the sphenoidal air cells consecutively, and there has been purulent infection in 21 out of the 22. From all of these the same micro-organisms were recovered from the sphenoidal air cells as were found in the lungs, and although in some the fluid was thin and only opalescent, in others there was regular thick creamy yellow pus. Such a high proportion of infected sphenoidal sinuses cannot have been accidental, and the fact points strongly to the importance of the upper respiratory passages and the nasal cavities as an important site of infective absorption.

Incidentally, I think this infection of the sphenoidal air cells also helps to explain why so many of the patients have a peculiar type of headache which is of a dull, heavy, boring character ("deep in at the back of the eyes," as the patients themselves describe it).

If, then, the nose and naso-pharynx has the importance in this connection that I deem it to have, it must be important to keep it as free from micro-organisms as possible, if one is obliged to be exposed to the possibility of infection from other individuals during an epidemic such as this one. To treat the mucous membrane with too strong a reagent or to irritate it too frequently is a mistake, because thereby one increases rather than diminishes its tendency to become attacked by micro-organisms passing over it, but to cleanse it of secretions at least once in twenty-four hours and preferably twice, by the use of a mild liquid antiseptic, is, in my opinion, a most useful measure in prophylaxis. It matters little, I think what antiseptic is employed provided it is not very irritating. It is the washing out of the nose and naso-pharynx which does as much good as does the antiseptic which is applied. A weak solution containing boric acid, a weak solution containing benzoic acid, a very weak solution of permanganate of potash, often plain salt and water, perhaps with a drop of carbolic to the ounce, will be most helpful, but it is important to draw the liquid up each nostril separately and out through the mouth in order to cleanse the back of the nose as well as the front, after which it helps a good deal, I think, to gargle the throat in a similar way, the two procedures together being described for short as "the nose and throat toilet," which should be performed night and morning in one's dressing room just in the same way as one cleans one's teeth.

There have been many complications of the disease apart from the pneumonia itself, two which are not common and yet are most striking when they do occur being subcutaneous emphysema of the thoracic wall and spontaneous rupture of the rectus abdominis muscles.

In quite a number of cases, as the result of a sudden coughing effort, as a rule, the patient has developed the very characteristic palpable crepitations beneath the skin that result from the escape of air into the subcutaneous tissues, precisely similar to that which is met with in fractured ribs for example. It is nearly always a very grave sign, because the usual pathology underlying the condition is as follows :—an embolic infarct having occurred in the lung, and the embolus itself containing pneumococci or streptococci, the surface of the

infarct become studded with a little group of from half a dozen to twenty tiny abscesses which are seen in the post-mortem room as pale areas, contrasting markedly with the deep red of the rest of the infarct. Pleurisy develops over the surface of these, so that the parietal and visceral layers become, as it were, glued together, and when one of the little abscesses has broken down sufficiently to pierce through the pleural covering, the opening that results passes through both visceral and parietal layers of pleura together, and air from within the lung escapes direct into the tissues of the chest wall; it may spread all over the surface of the chest and up the neck, and when it does occur it is a very striking feature of the case.

Rupture of a rectus abdominis muscle is familiar in typhoid fever, but is very uncommon indeed in ordinary influenza. It has been a not uncommon phenomenon, however, in the present epidemic. Preceding the rupture, there is apparently thrombosis of the vessels supplying the lower half of one or other, or both rectus abdominis muscles, and the affected sector, when seen post-mortem, is pulpy and hæmorrhagic, and in this state it is very liable to rupture in the course of the patient's coughing efforts. Before it ruptures, the affected part of the muscle is the site of acute pain, and if it is the lower half of the right rectus muscle that is thus involved, it is very easy to mistake the condition for acute appendicitis, for the patient is generally too ill to give an accurate account of where he has the pain, and the general impression his condition affords is that there is acute pain with rigidity over McBurney's spot, and in one such instance at least one has advised an urgent operation for acute appendicitis when what was found at the operation was acute necrosis of the rectus muscle, and no appendicitis at all.

Convalescence from the present influenza attack has been remarkable for its slowness in many instances; even when the original attack has been of the relatively mild type the patients have been many weeks before they felt really fit for work again; they have become fatigued very easily; they have felt that their brains would not work clearly for any length of time, and on any physical exertion they have easily become short of breath, or have perspired profusely; so that the length of time that they have had to stay away from work after an attack has often been very much longer than one would originally have expected. This serves as further evidence of the virulence of the toxæmia, and probably even in the mild cases there is much temporary damage in the form of cloudy swelling of the parenchymatous cells of many organs.

In conclusion I wish to emphasise the fact that in practically all the fatal cases the kidneys have been in a condition of acute nephritis, with kidneys of the congested, blood-oozing type, although during life there has been no œdema at all to attract notice to the kidney affection. If this condition has been so common in the fatal cases, I cannot help feeling that there must have been some degree of acute nephritis in at least many of those cases which recovered, and yet owing to the absence of œdema it may very easily have happened that the urine was not tested regularly during the course of the case. I feel sure that many of the cases complicated by nephritis have escaped detection, and I am afraid that many of these will some day come before us again as cases of chronic nephritis in which the origin of the nephritis may then be obscure. There is, as you know, a type of chronic tubal nephritis in which the patient has a small, pale, granular contracted kidney, precisely like that which results from a known previous attack of acute nephritis, for example, after scarlet fever, but in which the occurrence of any such previous attack of acute nephritis cannot be deter-

mined. It was Professor Sir John Rose Bradford who first emphasised this fact, and when one meets with pale granular contracted kidneys similar to those which would result from preceding acute nephritis, but in a case in which no preceding acute nephritis is known to have occurred, one speaks of the condition as being one of "Rose Bradford kidneys." What I am afraid is going to happen is that, owing to the non-detection of all the cases of nephritis that have occurred during the present influenza epidemic, a certain number of them will come before our notice again ten or fifteen years hence as cases of Rose Bradford kidney, and I would ask you to remember the possibility of these when you are presently in general practice. In any case I should like to close this clinical lecture by urging you to test the urine at regular intervals during the illness in every case of influenza of which you have charge.

[Permission to use the Plate accompanying this Lecture kindly granted by the Editor of the *Lancet*.]

Guy's Hospital Debating Society.

Annual Ladies' Night.

The Annual Ladies' Night Debate was held in the College Smoking Room on Thursday, March 20th, at 7.30 p.m. Dr. Fawcett was in the chair at the commencement, but unfortunately had to leave during the meeting, whereupon Sir W. Hale White took the chair.

The Chairman, after paying a warm tribute to the retiring President, Dr. Shaw, expresed his thanks to the members of the Society for electing him President. It was a great pleasure to see such a gathering, but at the same time one could not help missing those faces which would never be seen here again.

He then called upon Mrs. Wootton (Girton) to propose—"That in the opinion of this House the time has now arrived when Women should, in all respects, stand on an equal footing with men."

In an extremely able speech the Hon. Proposer stated that now, more than ever, was it essential for women to have equality with men. Great changes were necessary in society as a whole, so this was a good opportunity for changing the present condition of women.

The old Bible story of the creation of Eve from one of Adam's ribs was really a mistranslation! Adam was halved, and, from one of the halves, Eve was created! Thus, in the beginning, man and woman were equal, so why shouldn't they be equal now? Again, what was to be done with the large surplus of women? They must earn their living. The independence of women will not discourage marriage. The majority of educated women are much happier when married. They are, moreover, much more companionable to their husbands, and can bring up their children better. During the war it has been shown repeatedly, not only in hospitals, but also in offices, what good work women can do.

Mr. Maizels opposed the Motion. To put women on an equal footing with men was the same as saying that boiled eggs should be eaten with the fingers because bread was eaten with the fingers! Woman's place is the home, and it is her duty, to which she was assigned by Nature, to marry and bear children; whereas independence will discourage marriage. Take the case of primitive man. In those days man was the hunter and woman the housekeeper. Also girls are stigmatised for living in lodgings alone, and going to dances alone, etc. Woman is essentially more feminine than man is masculine.

Then, in industry, the women would undercut the men, and thus create still more unemployment at a time when this evil is already prevalent. The build- of the Channel Tunnel to create employment for discharged soldiers was quoted as an example.

Miss Sheldon supported the proposal from a sentimental point of view. Nowadays people maintain that women should go in for nursing, and yet when women first started nursing, when Florence Nightingale went out to the Crimea, it was considered frightfully wrong and very masculine! The root of the present trouble is that the women want an opportunity of showing their worth.

Miss Odlum (R.F.H.) then rose to support her "honourable chief." She admitted that she did not really agree with the Opposition! It was far better for girls to be held in restraint by convention, and it would also be better for young men if they, too, were held in greater restraint.

The discussion was opened by Mr. Layton. He stated that men act by judgment, whereas women act by instinct, and a woman's instinct is nearly always right. With regard to Miss Odlum's statement that young girls should be kept under restraint, in his opinion young men and women were equally irresponsible! This man-made world would be much better if women had a share in the making of it. He had had experience with both men and women

during the war, and showed the poor esteem in which a woman is held in Greece, where she is not even allowed to nurse her sick child!

Miss T. Lewellyn-Davis (Girton) was frankly amazed by the Hon. Opposer's speech! She imagined, by what he said, that this might be the year 1819, or even 1719, instead of 1919!

Mr. Turner failed to see why an educated woman could not make as happy a marriage as her uneducated sister. Suppose a man marries a woman B.Sc. They would be just as happy, and would say the same silly things about their elder children.

Miss D. Edwards (Girton) maintained that women would not undercut the men in the labour markets. There were not large battalions of women waiting to rush into the Channel Tunnel and seize the men's jobs as the Hon. Opposer seemed to think. If women were on an equality with men an employer would naturally employ men and women where they were respectively most efficient. Thus, they would tend to go into their own suitable fields of occupation, and one would eventually arrive at increased national wealth. Perhaps the best way out of the difficulty would be to kill off the surplus of women! (Loud applause.)

Miss G. Dancy (Girton) in reply to a statement that the women, who migrated to Paris from Whitehall, were granted £25 to show the Parisians how to dress, asked who gave the girls the money? Also, with regard to accusations against Government offices, surely the conditions in an office portray the character of the man at the head!

Mr. Barret (loud applause) stated that physiology was the only sound point of view. (But he never mentioned the subject again!) That man's brain is larger than woman's is shown by the statistics of the Tripos at Cambridge; also proving that men do better than women in examinations. The girls at the Ministry of Food spend their time playing cards. Business men in the City state that women are not so efficient as men, and employers are longing for the time when their men will return to their work.

Miss G. Sandes (R.F.H.), by a clever piece of juggling with mathematics, showed that the specific gravity of the grey matter in a woman's brain is lighter than that in a man's brain! Thus, a woman's brain might really be larger than a man's.

Miss Mayo (R.F.H.) asked how a girl could possibly show Paris how to dress on £25? The money was merely sufficient to cover her!

It was also pointed out that, whereas the women were given £25, the men were given £40.

Several other points of view were discussed, and women's position with regard to both inventions and architecture was the subject of many arguments.

Mr. Hume stated that women were not suitable for flying, but this was disproved. It was also maintained that men were just as neurotic as women.

As no other speakers rose to continue the debate, the Chairman then brought the discussion to a close. He would not attempt to state his own views on a subject which varied, as this had done, from primitive man right up to flying. He thanked the visitors warmly for their presence, and for the enjoyable evening which they had helped to provide.

Mr. Maizels was then called upon to sum up the Opposition. In reply to Miss Davis he stated that what he said in the year 1919 might apply also to the year 19 or even 2019. He still maintained that woman's place was the home, and from his own experience, when working with women, he had found that they were not so clever as men.

Mrs. Wootton replied for the proposition. In the present state of affairs women are at a great disadvantage. It is as if a man, standing on a table, asks a woman, standing on the floor, to show her worth. But if the man and woman were both on the table, one could push the other off, and thus women should be given the opportunity of showing whether they are worthy of equality with men or not.

The Chairman then put the Motion to the vote, whereupon it was carried by 134 votes to 33.

The meeting concluded with a hearty vote of thanks to Sir William Hale White for taking the chair.

The discussion was keenly contested from both sides, members' speeches being often interrupted by applause from the ends of the room, and hissing on the part of the visitors. It was also noticeable that the visitors did not seem anxious to put forward any original ideas, but rather waited for the men to speak, and then rose to pull their words to pieces.

The meeting was a great success, and so well attended (about 190 were present) that the seating accommodation of the Smoking Room was quite exhausted, many members being forced to stand.

The thanks of the Society are due to all, not only members of the Hospital and Nursing Staff, but also to the visitors, who so kindly contributed towards the success of the evening.

A MEETING of the society was held on Thursday, March 13th, at 4.30 p.m. Mr. Slesinger was in the chair.

Mr. Jeans proposed—"That the present Public School System, taken as a whole, is far from desirable." He maintained that science should be compulsory in schools up to a certain age, as it teaches boys to think for themselves. The form system should be abolished in favour of a class system. Games should be compulsory, but

boys should be allowed to keep up their own particular sports if they do not care for the school games. There should be better relations between masters and boys.

Mr. Braithwaite, in opposing the motion, stated that the public schools tend to produce a democratic spirit. Education takes place not only in the class room, but also on the playing fields and in the gymnasium, where boys are taught to play for their side, *i.e.*, patriotism. With regard to morals, the public schools are no worse than any private or board schools. The public schools have led the way during the war.

Mr. Rose did not see why only the children of the rich should be well educated, as in the present public school system. A boy who is good at games at a public school is regarded as a demigod, whereas a boy who is good at work is nobody.

Mr. Barrett stated that religion was given too much prominence in public schools. There is an indefinable something about the public school boy which makes the Englishman respected. The bad method of teaching is not the fault of the public schools, but of the Board of Education. If biology were taught to boys at the age of puberty, immorality would be minimised.

Mr. Burn held that public school training is aristocratic, and educates people only for positions as leaders of men. But now people must be trained for a different function, and to think for themselves. Religious influence prevents the development of intellectual freedom.

Mr. Lindsay thought that the present system is contrary to progress. Public school men, on the whole, leave school entirely unfitted to tackle the smallest social problem, and have no desire to do so. In these days changes should be introduced to enable them to hold their own in after-life against the better educated working man. Bluff will no longer take the place of sheer ability.

Mr. Mackenzie held that history should be more thoroughly taught. As the country has changed so the schools must change. Thus the public school men would learn to understand the labouring classes. Games are an excellent thing for boys at the age of puberty.

Mr. Braithwaite, in summing up the opposition, allowed that there were one or two points which ought to be changed. The Church, however, is the mother of education, and its influence can not be quite done away with.

Mr. Jeans replied that the necessity of the Church as the mother of education has gone. School governors should not be old parsons, as their experience is of a past age.

The motion was defeated by 4 votes to 9.

The meeting concluded with a vote of thanks to Mr. Slesinger for taking the chair. There were 35 members present.

Pass List.

University of London.

First Examination for Medical Degrees, March, 1919.

The following candidates proved themselves successful.—A. H. Brockbank, James Jemson, L. Lewinstein, N. L. Lloyd, Maurice Mitman, Harry Seelenfreund.

Second Examination for Medical Degrees.

Part I.

G. R. M. Apsey, W. G. Booth, D. A. L. Crawshaw, J. A. Currie, Emrys Jones, N. W. Mackeith, W. H. Ramsden, S. H. Robinson, C. H. C. Toussaint, E. C. Warner.

Part II.

G. E. W. Felce, W. Skelly.

Conjoint Board.

At the 2nd Professional Examination of Anatomy and Physiology, held on March 27th-31st and April 1st, the following candidates were successful.—A. B. Aldred, H. G. R. Canning, J. B. Gregor, G. B. Kirkland, S. P. Meacock, F. L. Rayner, L. K. Watson, B. C. Woodroffe.

At the quarterly Examination in Practical Pharmacy, held on April 3rd, the following were successful.—S. T. Barrett, W. H. Cellier, O. T. Maclaren, G. Packham, F. J. Smith.

L.D.S.

First Professional Examination for the Licence in Dental Surgery.

The following candidates were successful.—H. Ashling, †D. K. Evans, *W. H. Willis, H. P. Baylis, E. Clark, H. V. Croucher, F. W. Day, C. D. M. Dorward, J. E. H. Duckworth, *M. B. Goolding, I. Freiburger, R. Hughes, W. A. Krige, L. Lyon, G. M. Mew, F. J. Myers, *J. J. L. Hollington, *R. J. Hooker, C. S. Neame, P. Krige, †J. J. Du Toit, F. W. Stiven, *S. C. Bakle, *A. R. Cox, *F. Woodford.

†Mechanical Dentistry only.
*Dental Metallurgy only.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the Gazette *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

An Aberrant Renal Vessel causing Hydronephrosis.

Isabel H., æt. 30, married, was admitted into Mary Ward under Dr. Shaw on the 22nd of November, 1918, with pain in the left lumbar region.

She had had an attack of pain for the first time twelve months before.

The pain had been in the same position it was on admission and had disappeared on going to bed. The pain had returned nearly every month, and according to patient followed closely the onset of the menstrual periods.

Six weeks before admission patient gave birth to a six months' stillborn child. Patient complained of a gradual loss of weight in last year.

On admission patient looked pale and thin. Pulse 88; temperature 97; respirations 18. Chest normal. Cardio-vascular system normal. On bimanual palpation there was a definite tumour to be felt in left renal region. This tumour did not move on respiration, was very tender to touch and felt firm, smooth and solid. Bacteriological examination of urine on November 22nd, 1918—much pus present in this urine. Cultivation gave a growth of B. Coli.

A vaccine is being prepared. Patient was given vaccine in weekly doses and began to feel much better. The tumour, however, still remained. Dr. Shaw, discussing the diagnosis, said that a pyonephrosis seemed unlikely in view of the continued absence of any pyrexia or constitutional disturbance.

Tuberculous kidney or renal calculus was suggested and Mr. Rowlands was consulted. Radiographic examination failed to show a calculus in the left ureter or kidney.

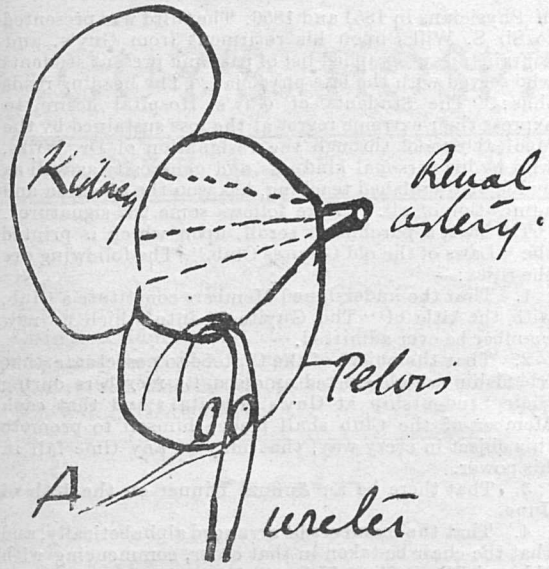
Mr. Rowlands cystoscoped patient following the injection of indigo-carmine into the thigh. The bladder was normal, but the excretion of the colouring matter by the left ureter was practically nothing compared with the excretion of the right ureter.

On account of this fact Mr. Rowlands immediately explored the left kidney, expecting to find a kinked ureter. On reaching the perinephric tissue through the usual renal incision he discovered a great deal of old inflammation of the perinephric tissue and experienced great difficulty in delivering the kidney.

At the low pole of the kidney there was a mass of old inflammatory tissue about the size of an egg. No explanation for this mass could be obtained, but he demonstrated that it in no way interferred with the ureter and could not have caused the condition of the kidney. The kidney was in a state of early hydronephrosis, the pelvis being large and bulging.

Tracing the ureter from below upwards, he found it quite normal until he reached a point one inch from the pelvis of the kidney, where he discovered the ureter to be definitely constricted and kinked. On further examination he noticed that this kink was being produced by abnormal branches of the renal artery and vein which were lying astride the ureter on its way to the lower pole of the kidney (*vide* diagram).

He ligatured and then cut these vessels. It was found impossible to straighten out the kink in the ureter, so Mr. Rowlands opened the pelvis of the kidney (from which some evil-smelling pus escaped), made an opening in the ureter below the kink and joined these two holes together, the operation short-circuiting the constriction in a manner similar to which a gastro-jejunostomy short circuits a pyloric constriction (*vide* diagram).



Posterior View of Left Kidney.

The ureter is kinked by abnormal branches of the renal vessels running behind the pelvis and in front of the ureter, which was thickened and permanently strictured as a result of the long-continued pressure of the abnormal vessels. Therefore, an anastomosis was made to drain the lower part of the pelvis at A.

A urinary fistula formed three days after the operation, but closed in five weeks, when the patient left the hospital in good health.

We are indebted to Dr. Shaw and Mr. Rowlands for permission to publish this case.

S. R.
G. H.

Correspondence.

To the Editor of Guy's Hospital Gazette.

Dear Sir,—There are just now many schemes of post-war reconstruction afoot in connection with the various Departments of the Hospital, and I should like to suggest to you that in no branch of the Hospital's work is re-organisation more needed than in that which deals with accidents.

During the last four and a half years surgery has experienced both a great set-back and a great advancement. The outbreak of the war found surgeons suddenly called upon to deal with a hitherto unparalleled number of infected wounds, and for a time aseptic surgery melted into oblivion, and there was practically a reversion to the conditions prevailing a hundred years ago. Gradually, however, the technique of dealing with infected wounds and compound fractures was improved until a perfection of treatment was attained, which has as yet hardly been recognised at all in civilian hospitals. Here, at Guy's, infected wounds are treated in much the same way as they were in 1913. To most of us the details of excision and primary suture of wounds, the treatment of compound fractures and wounds involving joints, as practised in Casualty Clearing Stations, are almost unknown. How many times in the past two years have we seen a Carrell-Dakin irrigation apparatus in use in this Hospital? Personally I can call to mind but three. We still see tubes put into infected joints and compound fractures.

There are now amongst us several members of the junior staff recently returned to the Hospital who have had an immense amount of experience in war surgery. Could it not be arranged that the accident wards be placed entirely in the charge of one or more of these men, whose function would be twofold—to treat and to to teach? The patients would then reap the benefit of the very latest and most approved treatment, and the rising generation would at the same time be instructed therein. In this connection it may be remarked that the public, mainly as a result of the large numbers of V.A.D.s who have been in France, are rapidly learning what they have a right to expect in the way of accident treatment, and will no longer be content with the old methods.

In conclusion then, Sir, I would enter a strong plea for the systematic practice and teaching of those methods of treatment which have been recently evolved, and so successfully carried out, in the casualty clearing stations and hospitals in France.—Yours faithfully,

ANON.

Dear Sir,—In the days of reconstruction it may be opportune to again draw attention to what has long been needed—a Hospital Motor Ambulance. There may exist would-be benefactors of this hospital who are waiting for some crystallised shape and form of their benefaction, and we can heartily commend to such the endowment and presentation of, a motor ambulance.

In our experience during take-in weeks—over and over again the disposal of cases not suitable for hospital treatment, yet requiring removal to Infirmary or Relieving Officer, etc., crops up—and usually at a late hour, when it is impossible to obtain a vehicle of any kind. Great inconvenience to all is caused—a waste of time in a vain endeavour to obtain some conveyance and perhaps ultimately involving a bed which should be employed otherwise.

Other hospitals possess ambulances, so that the method of working, cost, and sphere of usefulness could be ascertained.—Yours faithfully,

A. ALAN FORTY,
C. T. HELSHAM.

Guy's Hospital,
London, S.E. 1.
April 10th, 1919.

Guy's Hospital Employees' Social Club.

Mr. Robbins presided at a General Meeting of Hospital Employees held in the Pathological Theatre on Tuesday, April 8th, when it was unanimously decided to revive the above club, which has been suspended during the last two years of the war.

Mr. Croucher, in a very eloquent speech, brought before the meeting the main objects of the club. Looking round the theatre, he said, "There ought not to be any vacant gaps—in fact, the theatre should not be big enough to hold the hospital servants anxious to attend." He asked if there was anything the committee had not done to bring about unison between all employees of the Hospital and Medical School. Were there any complaints? If so, he would welcome any suggestions, so that these points could be remedied at once. He strongly urged that the club should be run on purely democratic lines, stating that after all we were all servants of Guy's and proud of the institution we serve. He thought that the club should go along very quietly through the summer months, with a Rambling Club and a social or two; then call a further general meeting and extend a cordial invitation to all officers and servants of every department to attend. Another event that he proposed to revive was the Annual Dinner, further impressing the meeting that it should be run on an equal social basis.

Mr. Arnold seconded the motion, which was carried unanimously.

Mr. J. H. E. Winstone, who was elected hon. sec. for the ensuing season, then proceeded to outline the principles for the formation of Rambling and Swimming Clubs. It was agreed to form a Rambling Club, and a committee consisting of Messrs. Baker, Walker and the hon. sec., was appointed to draw up a programme.

Mr. Arnold did not think it possible to commence a Cricket Club this season, owing to the expense that would be incurred in the initial outlay for kit, etc., and the difficulty of obtaining a ground. It was decided to leave this question to the next general meeting. Mr. Arnold agreed to bring his proposals before that meeting.

Mr. Croucher said that it was necessary to move with the spirit of the times, and proposed that an invitation be sent to the lay members of the Lady Administrative Staff to join the club. Since the war the Lady Staff had been very much augmented, and he thought that they should be admitted to the membership.

Mr. Beckwith seconded the proposal, and it was carried.

The proceedings terminated with a vote of thanks to the Chairman, who briefly responded.

A very successful Whist Drive followed, at which Mr. Turner took first prize with 185 points, Mr. Walker second, Mr. Lynch special number, and Mr. Cook the booby.

Mr. Curry very kindly presented the prizes to the successful competitors.

Guy's Hospital Museum of Antiquities.

Sir W. Hale White has very kindly presented to the Museum of Antiquities, four highly interesting manuscripts, belonging to the late Sir Samuel Wilks. The first two are diplomas obtained from the Royal College of Physicians in 1851 and 1856. The third was presented to Sir S. Wilks upon his retirment from Guy's, and contains an autographed list of past and present students who served with the late physician. The heading reads thus: "The Students of Guy's Hospital desire to express their extreme regret at the loss sustained by the Medical School through the resignation of Dr. Wilks, who by his personal kindness and generosity as well as by his distinguished teaching, has won the affection and admiration of all." Here follows some 282 signatures.

The last, a parchment scroll, upon which is printed the "Laws of the old Guyites Club." The following are the rules:—

1. That the undersigned Members constitute a Club, with the title of "The Guyites," into which no new member be ever admitted.
2. That the object of the Club be to perpetuate that friendship which existed amongst its members during their Studentship at Guy's Hospital; and that each Member of the Club shall pledge himself to promote this object in every way, that may at any time fall in his power.
3. That there be an Annual Dinner on the 18th of June.
4. That the members be arranged alphabetically, and that the chair be taken in that order, commencing with Edward Lloyd, Esq., M.D.
5. That the Secretary, with the Chairman, shall arrange all matters concerning the dinner, and that all expenses incurred shall be defrayed by the members consenting to be present.
6. That no guest be allowed under any circumstances.
7. That any member unavoidably prevented from attending the Annual Meeting, shall account for such absence in a letter to the Secretary, at the same time describing his adventures, &c., throughout the past year.
8. That these letters be kept unopened until after dinner, when they shall be read aloud, and that they be held and answered by the Secretary.
9. That a majority of those present at any Annual Meeting shall have the power of expelling a Member.
10. That Alfred Poland, Esq., of Guy's Hospital be Hon. Secretary and Treasurer.
11. That each Member on entering shall deposit the sum of One Guinea, and attach his signature to these Laws, written in a book provided by the Club, and kept by the Secretary, who shall enter an abstract of all proceedings of the Club.

Births.

GREEVES.—On March 24th, the wife of R. Affleck Greeves, F.R.C.S., of a daughter.

COLLINS.—On April 1st, at Ewell War Hospital, Epsom, the wife of Lieut.-Col. M. A. Collins, R.A.M.C., of a son.

MARRIOTT.—On March 4th, 1919, at Croydon, the wife of Dr. Oswald Marriott, of Hong Kong, of a son.

WILSON.—On March 29th, at Eagle House, Blandford, the wife of A. Read Wilson, M.D., of a son.

Death.

TOWNSEND.—Previously reported wounded and missing, on March 24th, 1918, now reported killed in action on that date, near Rocquigny, Capt. Thomas Ainsworth Townsend, M.C. and Bar and Order of St. Sava, R.A.M.C.(T.), 1/20th London Regt.

G. P. L.

GUY'S HOSPITAL GAZETTE.

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Passim.

MASSAGE AND RECONSTRUCTION.

At a time when reconstruction is the order of the day, and medical and surgical authorities are paying special heed to developments in their own particular spheres, when modern tendency inclines to destructive and subsequent constructive methods, Dr. Westman's article on "Massage and Medical Reconstruction" in the present issue of the GAZETTE must of necessity demand that special interest which always accompanies the work of the constructive factor. The interest excited sparks curiosity and leads to a keener appreciation of the importance of this therapeutic branch of medicine.

The experience of the past five years has demonstrated forcibly how vitally important was the part assigned to massage and kindred therapy. Rarely have other measures given so high a percentage of successes. Therefore, we heartily agree with the writer in his plea for a better knowledge and a keener appreciation of the great value of massage.

Circumstances necessitate such a knowledge, and the appeal is directed mainly to the unqualified and newly qualified men who in the near future will hold the destiny of medicine in their hands. They will be consulted, among other things, for after-treatment of wounds received in battle, and the disabled soldier has the right to expect an adequate knowledge of his doctor. Useless then to utter—

"The 'limb' is out of joint. O cursed spite
That ever I was born to set it right."

Massage, as a therapeutic measure, must be closely studied; and House Officers must see for themselves, as Dr. Westman suggests, what is being done. The Massage Department, however, seems to be an unattainable place to most men, and rarely does one see treatment being carried out. Unfortunately, too, more often than not the man who orders the treatment has but a hazy idea what is going to be done.

Such a state of affairs is deplorable and cries aloud for remedy. Truth to tell, it does exist because the student's interest is in no way stimulated, and he at length comes to believe that that branch is altogether out of his sphere of activity.

May we suggest as a remedy that demonstrations in massage and allied therapeutic measures be given to students either when they are in the dissecting room and their interest in anatomy is at its height, or when they are doing a surgical appointment or dressership in the Orthopædic Department, when they will

be able to appreciate more fully its therapeutic value. Dr. Westman demonstrates cases to the Masseuses on Mondays between 10.30 a.m. and 12 noon. If a sufficient number of men are interested, a like demonstration may be possible for them at any other convenient time.

League of Nations.

Even the optimist reading the terms of the "Covenant" of the Paris Conference cannot fail to realise what difficulties lie in the way of realisation. But, although there is likely to be considerable difference of opinion, at one time or another, over the industrial and political questions, one may at least anticipate that with regard to those problems affecting the physical and medical wellbeing of mankind in general, public opinion will be unanimous.

The Medical Profession will be particularly interested in the following articles :—

Article XXIII. (*c*).—Members will entrust the League of Nations with general supervision over the execution of agreements with regard to the traffic in women and children and the traffic in opium and other dangerous drugs.

(*f*) Members will endeavour to take steps in matters of international concern for the prevention and control of disease.

Article XXV.—The members of the League agree to encourage and promote the establishment and co-operation of duly authorised voluntary Red Cross organisations having as purposes the improvement of health, the prevention of disease, and the mitigation of suffering throughout the world.

During the last few years much time and money have been spent on propaganda against venereal disease, but, unfortunately the tuberculous question has been somewhat neglected. Let us hope that now an effort will be made to improve housing conditions, establish sanatoria, and make the eradication of consumption a reality and not a dream.

With regard to Article XXV., voluntary organisation is often rough and quite inadequate, and one thinks that the object in view is sufficiently important to justify payment for services.

Truly the articles quoted are ambiguous and vague enough to mean anything, and the man in the street questions whether his long-deferred hopes are to be realised or whether the well-turned phrases will remain merely—words, words, words.

Once again, it is with great regret that we say good-bye to the off-going residents who, during the past three months, have carried out the highest traditions of the Hospital. They carry with them the best wishes of everyone in the Hospital.

To the oncoming residents, some among whom we have pleasure in welcoming back from active service, we take this opportunity of offering our heartiest congratulations on their appointment and wishing them the very best of luck during the next three months. To no finer nor more competent men could the destinies of the Hospital be entrusted, and we are confident that the high standard of work will be maintained.

The greatest pleasure is felt at the election of Mr. Whitcombe as President and Mr. Harkness as Vice-President of the Residents, to whom in particular we offer our heartiest congratulations.

We should like to offer our heartiest congratulations to Mr. T. B. Layton, who has been appointed to deliver the Hunterian Lecture on Tuesday, May 6th, at the Royal College of Surgeons. The subject is, "The Surgical Aspects of the Collection and Transport of the

Wounded," and is a happy choice, for Mr. Layton has had a vast experience in matters relating to the transport of wounded during his long period of active service. Interest, too, is increased by a series of admirable photographs taken by the lecturer and others during the Palestine campaign; and we hope that all Guy's men will take the opportunity of hearing the lecture.

We consider it an honour and a privilege to be able to attract the attention of all our readers to the Nurses' Bazaar and Fête, which is to be held at Devonshire House, on May 1st, 2nd, and 3rd, with the noble end in view of creating a Benevolent Fund for Nurses in Sickness and distress. No body of women have ever deserved so well of a nation as have the nurses. During the strain and stress of five years' war they comported themselves admirably. Nothing was too strenuous for them to do, and self-preservation counted for little when the life of another was at stake. We owe them a debt of gratitude which can never be repaid, and the least we can do is to support so excellent a cause. Lady Perry is Chairman of the Bazaar Committee and will be pleased to receive gifts of all kinds. Judging by the weird and wondrous garments of all shapes and sizes which have appeared in the wards of late and which are destined for Guy's stall, we have no hesitation in anticipating a great success. May the real success far o'er-reach our highest anticipations.

We offer our heartiest congratulations to Mr. E. G. Slesinger on his Re-appointment of Research Scholar of the British Medical Association.

A letter received from Sir W. Hale White states that the four manuscripts (to which attention was drawn in our last number) belonging to the late Sir Samuel Wilks were presented not by him, but by Col. Charters Symonds. The thanks of the Hospital are due, therefore, to the latter for his extremely interesting gift.

Attention is drawn by Dr. Newton Pitt to the War Emergency Fund, which exists for the purpose of helping medical men who are in temporary financial difficulty owing to war service. Advantage will, we hope, be taken of this fund by men thus placed, and we trust that any of our readers who know of men similarly placed will at once communicate with them. The lot of the recently demobilised man, who has, perhaps, lost the whole of his practice through his patriotism, ought to be made as light as possible and assistance ought to be his right.

That sport is rapidly assuming its pre-war position becomes more and more evident as the number of names appended to the Swimming and Tennis lists daily becomes greater. We congratulate those whose energies have made this possible, and we hope that meetings will be called and officers elected before long, so that both these branches may be set on a firm basis.

All luck to the Guy's team in their match against the Pill Harriers, Newport, next Saturday.

We wish to draw attention to a letter which sets forth the principles upon which Dr. Lister an old Guy's man, is offering himself for election to the Senate of the University of London. We wish him all success, and hope that all Guy's men will do their utmost to enable him to reach his goal by giving him their vote. The advantages of having Guy's men on the Senate of the University are too obvious for mention.

Dr. Lister has made a close study of phthisis in all its aspects, and is the author of many papers on the subject. His energies are divided among many hospitals.

We are happy to be able to announce two more dances to be held in the Court Room on May 16th and 30th. Nothing more need be said to ensure success.

M. C

Appointments.

Medical School Appointments.

House Physicians.—Mr. G. B. Dowling (Dr. Fawcett), Mr. E. R. Webb (Dr. Beddard), Mr. D. M. P. Whitcombe (Dr. French), Mr. T. R. Trounce (Dr. Hurst).

House Surgeons.—Mr. A. H. Harkness (Sir A. Fripp), Mr. W. K. McKay (Mr. Steward), Mr. C. Sherris (Mr. Fagge). Mr. St. G. B. D. Gray (Mr. Rowlands).

Ophthalmic House Surgeon.—Mr. E. C. Hinde.

Obstetric Residents.—Mr. H. S. Groves (Mr. Bellingham Smith), Mr. C. H. Horwitz (Mr. Chapple), L. Lyne (Assistant).

Out-Patient Officers.—Messrs. T. G. D. Bonar, A. E. Sawday S. B. Wo ff.

Assistant House Surgeons.—Mr. W. G. Hay (Mr. Turner), Mr. V. E. Lloyd (Mr. Hughes), Mr. R. B. P. Lansdown (Mr. Bromley).

R.N.M.S.

The following appointments are announced by the Admiralty.—Surg.-Commdr. A. R. Bankart C.V.O., to the *Victoria and Albert.* Temp. Surg.-Lieut. G. H. Fitzgerald to the *Kinross.*

R.A.M.C.

The following relinquish the acting rank of Major on re-posting.—Temp. Capts. E. W. Sheaf, G. D. Eccles, G. W. Smith, A. H. Spicer.

Major H. O. M. Beadnell is placed temporarily on the half-pay list owing to ill-health.

Acting Capt. C. J. Henry reverts to Lieut. R.F.A., S.R., on demobilisation.

The undermentioned officers relinquish their commissions and retain the rank of Capt.—Capts. B. B. Westlake, T. R. Trounce, G. D. Eccles, A. A. Greenwood, C. S. L. Roberts, G. Maxted, H. C. Malleson, H. Barber.

Col. A. W. Sheen, R.A.M.C., relinquishes the appointment of Consulting Surgeon, War Hospitals, India, and has returned to Cardiff.

Special Reserve.

Capt. H. G. Crawford relinquishes the acting rank of Major on re-posting.

Civil.

E. B. Hinde, M.B., B.Ch. Cantab., F.R.C.S. Edin., to be Asst. Surg. to the Jenny Lind Hospital for Children, Norwich.

Change of Address.

Col. A. W. Sheen, R.A.M.C., 23, Windsor Place, Cardiff.

E. Lionel Elliott, M.B., B.S., Stokenchurch (Bucks), near Wallingford, Bucks (on demobilisation).

Capt. H. S. Wacher, I.M.S., 9, St. George's Place, Canterbury (on demobilisation).

C. L. Odam, 91, Breakspears Road, Brockley, S.E.

A. A. Greenwood, 55, Crouch Hall Road, Crouch End, N. 8.

Capt. G. T. Foster-Smith, 58, Treen Avenue, Barnes, S.W.

Capt. W. H. Ogilvie, R.A.M.C., from B.E.F., Italy, to Military Orthopædic Hospital, Birmingham.

Lieut. S. A. Withers, R.A.M.C., Base Isolation Hospital, Mesopotamia E.F.

Major F. E. Hutchinson, R.A.M.C., 37, Doughty Street, London, W.C.

Capt. Donald Clewer, No. 25 General Hospital, B.E.F., Army of the Rhine.

Hildred Carlill, M.D., F.R.C.P., from R.N. Hospital, Haslar, to 146, Harley Street, W. 1 (Tel. Mayfair 4054), on demobilisation).

Miss A. M. Daniels, Q.A.I.M.N.S.R., The Birches, Statham, Norfolk.

Miss B. H. Daniels, R.R.C., *Ibid.*

C. J. Henry, M.C., L.D.S., from 113 Battery, R.F.A. (S.R.), to 79, King William Street, E.C. 4.

Papers by Guy's Men.

G. F. H. Bloom, L.D.S., R.C.S.: Common Salt and Erosion: a Thesis.—*Brit. Dent. Journ.*, April 15th, 1919.

Frank Shufflebotham, M.D.: Influenza among poison gas workers.—*B.M.J.*, April 19th, 1919.

E. G. Slesinger, M.B., B.S., B.Sc., F.R.C.S.: The treatment of suppuration.—*Hospital*, April 26th, 1919.

Surg.-Commdr. W. K. Wills, R.N.V.R.: The Naval Medical Service.—*B.M.J.*, April 26th, 1919.

F. Gowland Hopkins, M.B., D.Sc., F.R.C.P., F.R.S.: The Practical Importance of Vitamines.—*B.M.J.*, April 26th, 1919.

Massage and Medical Reconstruction.

By CARL WESTMAN, M.R.C.S., L.R.C.P.,

Medical Officer i/c the Massage and Electro-Therapeutic Department, Great Northern Central Hospital; Chief Clinical Assistant, Massage Department, Guy's Hospital.

There are clear signs that medical education in this country is on the eve of reformation, and that matters which come within the sphere of medicine and surgery will be subjected to examination and criticism with a view to bringing about an improvement in the methods of teaching.

It is, of course, common knowledge that the various therapeutic departments have so far received very litttle attention from those who have the responsibility of training medical students, with the result that the latter rarely, if ever, pay visits to these departments. Yet it would not seem unreasonable to expect that the future practitioner should possess some knowledge of the utility and the principles that underlie such widely used treatments as massage and electricity, for he will be expected to give advice to his patients as regards special treatment, and to know in which cases this or that treatment would be suitable.

This subject has already received some attention. In the "Guy's Hospital Gazette" of the 7th September, 1918, the Editor, in his "Passim," urged the House Officers to visit the Massage Department and see for themselves the work being done. A further stimulus was given by Sir William Hale White in his admirable article in the *Lancet* on December 4th on Medical Reconstruction. He said that "the medical school should have attached to it the necessary therapeutic departments, massage, etc., in which the student *can see the carrying out* of all these special treatments. The physician should frequent the departments where the special treatments are carried out, and he must keep himself abreast with all new therapeutic suggestions." It would, perhaps, be of interest to examine this subject in detail to see what practical benefit might be gained by some step in the aforesaid direction.

I propose dealing solely with the department for manipulative treatment, or massage as it is unfortunately more generally called, in the hope that others who are more qualified will come forth and speak for the sister departments.

It is not very long since massage treatment was carried out almost entirely by men and women from foreign countries, chiefly Sweden, where the treatment originated on a scientific basis and where a genuine training has always been afforded to students. Gradually, however, English women began to take an interest in it and soon organised themselves into a strong association which gives the standardised diploma for practice. At the beginning of the war and during its progress the number of masseuses increased considerably. The call to do their share in the care of the wounded was responded to in a magnificent way by thousands of women, who flocked to the various training schools in order to qualify themselves for this branch of service.

Let it be admitted at once they have done a most excellent and important work. They have ungrudgingly, and with a keen interest in their cases, spent many long hours in executing a work which—if properly carried out—claims close attention, and is often of a very fatiguing nature. Although many of these women have now given up this war-work, there are undoubtedly many who wish to remain in or adopt the profession. We shall thus have a much larger number of experienced mas-

senses available for the ordinary peace work. So far so good. Owing to the great part which massage treatment has played during the war a much wider attention has been bestowed upon it than heretofore; and I believe that it is well on the way to establish itself as a sound therapeutic branch, based on common sense and a rational application of the bodily sciences. Viewed in this light, and with due respect and consideration for other methods of treatment, there is every likelihood of its wider application in the future.

It seems, therefore, that the present time is highly suitable for considering whether all is well with the massage treatment, or whether there are not several points connected with it that we should endeavour to improve before recommending its further application. The motto of the present time is *reconstruction*, and it seems to me that there are four main lines along which this reconstruction should proceed in matters relating to massage treatment.

1. *Massage and the Training of Medical Students.*—For the successful and most useful application of massage treatment, and to assure its development along correct and scientific lines, it is highly desirable that there should be a greater number of medical men and women professing special knowledge of this subject. Important and necessary as the work of the masseuses is, and always will be, their necessarily limited amount of training does not qualify them to guide and develop the treatment correctly. To gain this object, medical students, who evince interest, should be given opportunity of obtaining such instruction in manipulative treatment as would enable them to become specialists in this subject. Seeing that almost every large general hospital in London has its massage school, there should be no great difficulty in arranging this, and obvious advantages would be gained thereby. Medical practitioners thus trained would become the link between the profession as a whole and those who have the immediate treatment in hand, and would thus be able to serve the interests of both to the benefit of the patients. They would generally uphold the standard of treatment and see to its application and advancement along scientific lines. They would serve as medical officers in charge of the Massage Departments at the general hospitals. There they would supervise the work and give directions, as regards the essentials, in the treatment of each patient. This is of especial importance; for *results, and the speed with which they are obtained, entirely depend upon the particular way the treatment is carried out.* Considerable time and labour is often wasted by masseuses owing to lack of guidance from one who has a deeper knowledge of the human body and its intrinsic character, and who at the same time possesses special knowledge of the treatment in question. Though the diagnosis of cases sent to the Massage Departments should be made before their admittance, this has often to be worked out in detail or modified, as occasion demands and the treatment proceeds. Let us take just one example—the case of some organic injury, say a bruised shoulder with a consequent inability to abduct the arm from swelling and pain. This originally genuine inability not infrequently merges into one of a hysterical or malingering nature, or a combination of both. Such developments should obviously be detected and the treatment changed accordingly; but this is a case for the medical officer and not for the masseuse.

The medical student rarely, if ever, visits the Massage Department either of his own free will or by compulsion, although a very large percentage of his surgical cases, and a smaller percentage of medical, ultimately proceed there for after-treatment. By the omission of these visits the student misses opportunities of practical

experience which will never return. Not only would it be highly instructive for him to follow the progress of his cases in the Massage Department and enable him to prove his ability of giving a correct prognosis, but it would also make him familiar with a treatment with which he will certainly have to deal in his future career.

A student who availed himself of this special instruction would, I feel sure, gain knowledge which would be of real benefit to him even if he did not intend to become a therapeutic specialist. If, for example, he had daily to manipulate a fractured limb or to re-educate a paretic group of muscles, he would develop that "touch" which would be invaluable to him later on. It has been rightly said by senior men, who in their younger days were taught to rely more on observation and "touch" than on skiagrams and bismuth meals, that how ever valuable these latter are, it is deplorable that so much attention should be paid to what are, after all, only adjuncts to clinical observation and so little to the direct examination by inspection and palpation. How many obscure neuralgias, due to infiltration in deeper lying tissues, are missed by the man who is lacking in "touch," with consequent delay in the patient's recovery! In the examination of a joint, how valuable—is it not?—for the surgeon or physician to have his muscular sense acutely developed. By this very means is he enabled to judge the range of mobility, and to what extent an obstructed movement is due to a pathological condition or merely to functional contraction of guiding muscles. Many a "stiff" joint is freely mobile but for the contraction of surrounding muscles, which condition will remain for a considerable time, if not early recognised and properly handled. In developing the sense of touch the art of palpation would be attained far sooner by practice in the massage department.

The power of observation must be developed equally with the general fitness for examination of limbs. Furthermore, the execution of massage treatment offers an excellent opportunity for the study of topographical anatomy.

2. *The Training of the Masseuse* is a matter of paramount importance, since to her belongs the immediate and daily charge of the patient, and the results of the treatment depend very much upon *her* skill in restoring function to a more or less lifeless part. This is a point which cannot be too strongly emphasised. If I now venture upon some general criticism I do so in a spirit of highest consideration for the work of the masseuse, and in the hope that improved methods of training will make her work of a still higher quality, and give her a greater power of grasping the patient's needs.

The diploma granted for the practice of massage after a six months' course only is unfortunate, as it can scarcely convey a sufficient knowledge to ensure a correct application of a manifold treatment. Most of the time is necessarily taken up with theoretical study and practice of the various manipulations of massage, while the study of movements, their physiology and practical execution, is relegated to the background. This six months' diploma is, to my mind, largely responsible for the *excessive amount of passive* and the *insufficient amount of active re-educative work* in the Massage Departments. We see far too much of the nice, comfortable, and soothing stroking of a limb, and far too little of the brisk and encouraging kind of treatment which compels the patient to try his utmost in executing a movement. In other words, there is too much active work on the part of the masseuse and too little on the part of the patient. The majority of the patients who visit the Massage Departments do so in order to get function restored in their limbs. *Re-education* is, therefore, a

word that should be ever before the mind of the masseuse. Unfortunately its importance is at present but feebly recognised. The result is tardy progress and waste of time. Moreover, I am convinced that in many cases positive harm is done, in that what was originally an organic disability is converted into a hysterical one by too much passive treatment, which to a receptive mind is suggestive of great disability. *Suggestive re-educative movements* ought to claim a much larger share in the treatment, and in a large number of cases this is the only treatment required. That cases sent to the Massage Departments must necessarily have massage in some form or other is a natural though unfortunate misconception, and one remedy that seems reasonable and feasible is to give the Department a different name, such as Physical or Mechano-Therapeutic.

Improved methods of training and the abolition of the six months' diploma would, I feel sure, go a long way towards raising the standard of the masseuse and bringing the treatment more into line with the new discoveries and experience gained during the war.

3. *Massage and Electric Treatment.*—One cannot but hope that in future there will be more co-operation between the departments for massage and electricity. The simpler kinds of electricity, such as the faradic and galvanic currents, should be part of the outfit in the Massage Departments. Experience tells me that these two methods of treatment prove extremely effective in combination and that much would be gained by their more intimate co-operation.

4. *Registration and Quackery.*—Bearing in mind how easily the massage treatment lends itself to abuse by undesirable persons, it is to be hoped that the future will provide us with legalised medical recognition in the form of a professional register of persons practising the treatment, though otherwise medically unqualified.

It is of equal importance, however, to safeguard the public against quackery. Would it not be advisable to make it a punishable offence for a recognised masseur or masseuse to undertake the treatment of any case without the sanction or advice of a medical practitioner? This would at once remove an anomaly which I feel is hindering the mutual feeling of confidence between the medical practitioner and the massage experts at the present time, viz., the misconception on the part of some of the latter as regards their professional standing. Not infrequently do they take upon themselves the responsibility of diagnosis, and independently of any recognised medical authority take recourse to their one study, viz., massage in one or other form.

Modern physicians and surgeons are well aware of the utility of manipulative treatment, but they do not always recognise the supreme importance of training the masseuses.

Who can fail to see the difference between the work of the painter-artist and the house-decorator, though both use the same instruments, paint and brush? Equally great is the distinction between the skilful and intelligent masseuse and her imitator, though they both do their work solely with their hands.

Summary of Suggestions.

1. Compulsory visits for all medical students to the Massage Departments and opportunity for special training for those interested, such course to run concurrently with the medical studies.

2. The adaptation and development of the treatment along scientific and rational lines.

3. A revised and standardised training for masseuses (and masseurs) with abolition of the six months' course diploma.

4. The formation of a professional register of persons qualified to practise massage, and new laws against quackery.

This article which was written expressly for the "Journal of the Incorporated Society of Masseuses" is to appear in its May number.

Guy's Hospital Dental Society.

A special meeting of the Society was held on the 11th April, at 8 p.m., in the Anatomical Theatre. The President, Mr. Montague F. Hopson, occupied the chair.

Mr. S. H. Coplans (Acting Hon. Sec.) read the minutes, which, with an amendment (moved by Mr. Hopson) to the effect that "this meeting should be a special meeting for the purpose of electing on Hon. Treasurer," were passed for signature.

Mr. Hopson then called upon Mr. Grieve for a proposal for the post of Hon. Treasurer. Mr. Grieve proposed Mr. S. H. Coplans. Mr. James seconded the motion, which was carried unanimously. Mr. Coplans was then declared elected by the Chairman, and the special business being disposed of, he declared the special meeting adjourned, the meeting to continue as an ordinary one.

Mr. Hopson then called upon Mr. Doubleday to read his paper on "Local Anæsthesia in Dental Operations." This was practically a resumé of a paper he read before the Odontological Section of the Royal Society of Medicine, on July 8th, 1918. We propose, therefore, to publish this paper now, and we take the opportunity to thank Mr. Doubleday for his kind permission to do so.

On Local Anæsthesia in Dental Operations.

As the advent of general anæsthesia rendered possible the advances of modern surgery, so, I am confident, will local anæsthesia in the future render similar service to the dental surgeon by abolishing pain from his field of surgery. Twelve years ago, when my experiments upon local anæsthesia commenced, we were using cocaine, and experimenting with β-eucaine lactate and similar drugs. Doubtless further experience will lead to the discovery of new and better anæsthetic agents, but my experience leads me to believe that novocain is at present the safest and most satisfactory drug. The E tablets, containing 0·02 grm. of novocain and 0·00005 grm. of suprarenin are employed, one to each cubic centimetre of water, making a 2 per cent. solution of novocain. By observing the effects of solutions of tap water, normal saline, and Ringer's solution upon myself and upon patients, I have found that on the tissues there is little difference between tap water and saline solution as regards the irritation produced. Three cubic centimetres of boiling water are put into a graduated test tube, three novocain E tablets are added, the whole is boiled, and poured into a sterile drug holder; this is then drawn into a sterilized all-metal syringe, the needle is screwed into the syringe, turned nozzle upward, and tapped, to free from all air. The solution is then ready for use. If the patient has previously shown signs of susceptibility to the drug, strychnine sulphate 0·0022 grm. or atropine sulphate 0·00065 grm. is added to the solution before boiling it. If the blood-pressure is excessively high, as may occur in alcoholics, an inhalation of amyl nitrite

is given before the injection to reduce the blood-pressure, for suprarenin will restore it to the normal height. The all-metal syringe fitted with a vulcanite washer, can be boiled. A short hub, with two types of needle, the short one 2 cm., and the long one 4 cm. in length, with a bayonet attachment, complete the equipment. Before inserting a needle into the soft tissues these are dried and painted with tinct. iodi. (6 per cent.).

The following are the methods of inducing anæsthesia :—

Submucous infiltration for the anæsthetisation of the nerve-twigs going to the pulp and periodontal membrane, being used for filling of teeth, or for their immediate separation. It is employed for all the teeth, except the lower molars.

In the case of the maxillary incisors, canines, and pre-molars, the lip is held away from the jaw to expose the reflection of the mucous membrane from the gum to the cheek. Into the midpoint of this reflection the short needle is passed with a sharp thrust. Some resistance is encountered in the submucous tissue, but as soon as the cellular tissue of the cheek is entered the passage of the needle is easy. Half the length of the needle is introduced so that its injecting surface lies above and rather posterior to the nerve-twig in its passage through the maxilla to the apex of the root. The needle lies outside the periosteum, but does not pierce it. Two to 3 c.c. of the solution are then injected into the part not too slowly, but without forcibly producing distension of the tissues. This usually takes about thirty seconds; generally at the end of that time, always within two minutes, the pulp, dentine, and periodontal membrane will be quite insensitive. In the case of the mandible the technique is similar, but the injecting surface of the needle should be more directly beneath the apex of the root, because of the different course pursued by the nerves as they pass to the teeth.

Submucous anæsthesia of the maxillary molar teeth is obtained by utilising the bayonet attachment, with the short needle, the injecting surface of the needle being directed forwards and inwards ; the mouth should be nearly closed, the needle is passed into the reflection of the mucous membrane opposite the maxillary third molar and directed upwards and inwards until the posterior superior dental foramina are reached. Their position depends upon the development of the maxillary antrum ; sometimes the injecting surface of the needle is opposite the foramina when the hub of the needle is at the occlusal margin of the third molar, and sometimes when the hub is at the cervical margin; the needle is moved slowly up and down, bathing the whole of this surface with 2 or 3 c.c. of the solution. Care is taken to have the needle too high rather than too low; gravity will tend to make the fluid descend along the bony, muscular, and fascial planes.

Alveolar anæsthesia is, I believe, generally employed by dental practitioners in extraction of one or two teeth, and answers well except in the case of the lower molars. The injecting surface of the needle is passed beneath the gum, but not beneath the periosteum of the alveolar process of the tooth to be extracted; about 7 minims of the solution are inserted upon the vestibular and oral surfaces of the tooth. Anæsthesia is practically instantaneous.

Intra-alveolar anæsthesia is advocated by Mr. Parrott, of the Dental School of Birmingham, for obtaining anæsthesia in the molar region of the mandible. A few drops of the solution having been inserted beneath the gum upon the buccal surface of the root, a small opening is drilled through the outer alveolar plate into

the cancellous tissue of the mandible; through this opening the needle is inserted, and a few minims of the solution are injected. Very satisfactory anæsthesia is obtained. Personally I do not care to take the risk of introducing sepsis into the cancellous tissues of the mandible. Regional anæsthesia, which we constantly employed in Berlin in 1909—10, at first inspired me with apprehension, but as I found that Mr. Rowlett and Major Kazanjian constantly used it with safety and success, their example has led me again to adopt regional anæsthesia. Sometime, possibly, I may employ Mr. Parrott's method, since it has proved successful in a base hospital in France.

Regional Anæsthesia in the Maxilla.—For this a bayonet attachment is added to the syringe; a long needle is employed if complete blocking of the infra-orbital nerve is required. The needle is inserted as nearly as possible in line with the buccal roots of the third molar, the patient having the teeth almost closed; the direction of the needle is upwards and inwards, towards the midline; its injecting surface is directed forwards towards the posterior surface of the maxilla. About 2 c.c. of the solution are introduced.

Regional Anæsthesia in the Mandible.—Two useful methods may be utilised for this purpose: (*a*) A short hub and long needle are employed. The patient has his mouth open 4-cm. The needle is passed over the pre-molar teeth of the opposite side, into the inner third of the anterior pillar of the fauces on the side to be anæsthetised. The needle will lie just below the occlusal surface of the upper third molar, having its injecting surface directed towards the bone. It is then passed back into a triangular space, having its base uppermost formed by the external pterygoid muscle, its inner wall formed by the internal lateral ligament and the internal pterygoid muscle, and its apex by the attachment of these to the mandible. By passing the needle in for half its depth the injecting surface will lie above and posterior to the lingula, covering the commencement of the inferior dental (alveolar) canal; 2 c.c. of the solution is then intruduced. (*b*) The bayonet attachment and short needle are employed. The technique of injection is similar to the above, but the short needle is used. Its advantage lies in the fact that it can be utilised when the patient cannot, or will not, open the mouth widely.

In comparing these methods, one must remember the three standards to which local anæsthesia should conform: (1) Simplicity of technique; (2) rapid and certain onset of anæsthesia; (3) absence of after-effects. Submucous anæsthesia is the simplest, and for filling teeth is unrivalled. For the extraction of teeth the alveolar anæsthesia is the most simple; while regional anæsthesia is invaluable for all operations upon the mandibular molars and for multiple extractions.

Some typical instances of the uses of local anæsthesia are as follows:—

On July 5th, 1918, Mrs. J.—Devitalisation and removal of the pulp of the maxillary left central incisors was necessary. A submucous anæsthesia was administered at 10.20, and the pulp exposed and removed without pain at 10.25.

On July 4th, Dr. X. was given a mandibular regional anæsthesia for the extraction of a broken-down second molar at 10.30. At 11 the tooth was removed without pain, though he was a very nervous and sceptical patient.

On May 3rd, Mrs. D.—The extraction of a crowned second mandibular pre-molar which had an acute abscess upon its root, was necessary. She was five months pregnant, and particularly

desired to avoid a general anæsthetic. A mandibular regional anæsthesia was given at 2.10, the tooth removed, and pus evacuated without pain at 3 p.m.

On April 9th, Miss I., suffering from acute local periodontitis of the mandibular second molar; the tooth was too tender to bite on or to touch. A mandibular regional was given at 11.30. At 12.30 an amalgam filling in the tooth was removed without pain, the root canals opened up, and the tooth eventually saved.

On July 8th, A. B. presented himself for the removal of a small cyst in the region of an upper first molar. At 10.10 a submucous injection was given, also an injection to catch the posterior palatine nerve as it emerges from the posterior palatine foramen. At 10.20 the operation was commenced and completed without pain, although it lasted forty-five minutes, and involved a good deal of chiselling away of compact bone.

A Toxic Case.—On July 5th, Miss H. presented herself for the devitalisation of the maxillary left canine and the preparation of cavities in both maxillary pre-molars of the same side. A maxillary regional anæsthesia was administered at 9.30. At 9.55 the patient showed some blueness of her lips and slight sweating, and within half a minute fainted. She was at once given strychnine sulp. 0·0022 grm. in 1 c.c. of water, and within another half minute her pulse had recovered. She apologised for her stupidity, which she attributed to the rubber dam interfering with her respiration. I think, however, that her symptoms were really due to absorption of novocain.

Although I have used the drug in my private and hospital practice four or five times daily for several years, I have never seen a worse case than this, and believe that if only freshly made solutions were injected with absolutely sterile instruments, toxæmia would very seldom occur. Blueness of the lips and sweating over the upper lip are the early signs of novocain poisoning, and should be at once combated by the administration of strychnine as above.

I desire to acknowledge my indebtedness to Mr. Hancock, Anatomical Curator to Guy's Hospital, for the admirable dissections which he has made, and lent for the purpose of the demonstration.

[The methods of inducing local anæsthesia were then demonstrated, by means of skulls and dissections, upon the epidiascope.]

An interesting and lively discussion ensued which was all the more helpful to all concerned because many of those present had worked with Mr. Doubleday, and were able to give their personal experiences of the different methods demonstrated. Those who took part in the discussion were Messrs. Hopson, Layton, Malleson, Bull, Coplans, James, Lauer, Greenwall, Moody and Whelpton.

Tea and coffee was served in the Library afterwards. About 45 members were present, and although this represents an advance on the last meeting, the committee are not yet satisfied, and they express the hope that members will turn up in still greater numbers to the meetings next term.

Do not forget that the Dental Dinner is to be held on May 10th, at the Connaught Rooms, at 6.30. Get your tickets early from the Hon. Dinner Secretary, Mr. F. B. Bull, 24, St. Thomas's Street.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of Guy's Hospital Gazette.

[We would point out that we cannot *in any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—Ed., G.H.G.]

The Guy's War Memorial.

Sir,—An absence of four years in the Mediterranean Command must be my excuse for adding further to the contents of your letter bag dealing with the Guy's War Memorial. For many of us who have served abroad mails have been uncertain. We know but imperfectly the names of those who have gone west, still less of the women who have a legacy of grand memories and the miserable pittance of a Government pension at a time when the pre-war sovereign is worth about eight shillings. I can realise at once that there may be objections to publishing in the Gazette a list of widows and fatherless children, but speaking again on behalf of many who have been on the Mediterranean Station, we long to know these details and hope that it may be possible to publish them—perhaps for private circulation only—among old Guy's men. We feel that before any memorial tablet, or monument or building is projected, our duty is plain: it is to ensure that we do not overlook the need of the Guy's widows in an eagerness to perpetuate the memory of our friends. In some cases the Guy's widow is also a woman who has been a nurse at Guy's, and the responsibility is on that account the greater. These questions have no doubt been considered by those who have had all the labour of starting the Memorial Fund, but so far a definite goal is not designated and the eventual result is uncertain. This is a mistake. No such mistake is being made by my old public-school, where provision for widows and children is to be satisfied before any money is spent upon bricks and mortar, minarets and masonry.

Then, again, suggestions have been advanced that on behalf of the children, medical scholarships should be provided for boys and a nursing training for the diploma of the Royal College of Nursing—I speak in "futurist" language—promised for girls, both of these studentships, so I understand, to be held at Guy's. Were this the ultimate outlook of the fund, it seems to me that you are levelling a revolver disguised as a stethoscope or hidden under a nurse's apron at the head of every Guy's widow. You have nothing else to present, and you are ignorant as to whether the boy has any of those qualities essential for a medical man, whether the character of the girl is likely to develop along lines which will fit her for the profession of a nurse. Granted that the income of the widow is adequate and remembering from experience of South African War Memorial Funds how often those who are suffering most will maintain silence, then, before any question of medical or nursing training is raised, it seems to be essential that there should be assured for each boy an education at a public school—such as Marlborough or Dulwich or Bedford—for at least five years, and for each girl a similar period at a good modern school.

Once more, even supposing that a medical or nursing education appears to be indicated, has anyone considered how emigration is likely to affect our national life in the course of the next twenty years? It may be necessary, for financial reasons that the Guy's widow should emigrate, in which case the boy might, of necessity be compelled to go to school and to take his degree in Montreal or in Christchurch, New Zealand, or in Grahamstown, South Africa, for the war, after gathering our race from the four corners of the world, is also going to scatter us again, even more widely than before. What help are you proposing under such circumstances?

Perhaps it is that, for some of us, the horizon is no longer so limited and the front quadrangle is no longer bounded by the surgical instrument show-rooms of Messrs. Down Bros.

On a destroyer in the Eastern Mediterranean I read Mr. Ormond's eloquent appeal for a memorial which should be something lasting and beautiful to look upon, but Athens, under bombardment by the Allies in December, 1916, is a reminder to me of how even the monuments of Phidias and Praxiteles may perish even at the hands of friends.

Sir, I have overburdened you too long with my thoughts, I have wearied your readers, and thoroughly annoyed some of the generous subscribers to this excellent fund, which as yet has no objective, but in that case you will receive so vast a correspondence that the circulation of your carefully edited journal will be

rising, your anxieties will be at an end, and there will be no need for me to weary you with another letter of profuse and completely Oriental apology.

Under the circumstances I am bold enough to sign my name.—I am, Sir, etc.,

14th April, 1919. H. CORRY MANN.

DEAR SIR,—I wish to draw the attention of recently demobilised medical men who may find themselves in temporary financial difficulties, arising from the loss of income from practice, owing to their absence at the War, to the War Emergency Fund.

This Fund exists for the purpose of helping such doctors by making grants especially towards the payment of school fees, insurance premiums and rent, during the first year while they are re-establishing themselves in their old practices.

The committee meet monthly to consider applications, which are dealt with anonymously.

Applications for grants should be made to the War Emergency Fund, 11, Chandos Stret, W. 1.—I am, Sir, yours obediently, G. NEWTON PITT,

22nd April, 1919. Hon. Sec.

SIR,—Your issue of April 5th offers proof of a strong desire for a *good* visible memorial of those Guy's men who have fallen during the war, and I wish to add to this proof my own support.

The memorial could be equally appropriate either in the form of statuary or in the form of additional accommodation and in connection with the latter, the crying need for a children's ward deserves consideration.

As one correspondent points out, the scheme for a Students' Hostel is a business matter, and would be more suitably set going as the concern of a private company than as a memorial; and it is essential that any memorial should be actually in the buildings of Guy's Hospital, and that it should show a generosity of appreciation undiluted with convenient utilitarianism.

The letter from Dr. Hale White and the reports of the Auxiliary R.A.M.C. Fund, show how small is the need for a relief fund as suggested by Mr. Layton.—Yours faithfully,

Havre, H. WEBB.

9th April, 1919.

University of London Senatorial Election.

SIR,—The forthcoming election to the Senate of the University of London of a medical representative is of peculiar interest, especially to Guy's men. Dr. Thomas David Lister, who was house-surgeon at Guy's in 1893–4, is offering himself for election and has been adopted as the candidate of the University of London Graduates' Association. Dr. Lister favours (1) the maintenance of the high standard of the London Degrees; (2) the conserving of the internal and external sides of the University as at present. He is entirely opposed to the reconstruction of the University on the German model, as suggested by the Report of the Haldane Commission.—Yours faithfully, A. PERCY ALLAN.

Crogdene, Croham Road,
South Croydon,
24th April, 1919.

Guy's War Memorial Fund.

	£	s.	d.
Brought forward ...	£3,221	17	8
Sharwood, W.	2	2	0
Dodd, F. H.	1	1	0
Staley, R. C. W.	2	2	0
Reeves, A.	3	3	0
Partridge, A. A. H.	2	2	0
*Bell Walker, H. F.	10	0	0
Eccles, H. N.	2	2	0
Sutton, C. R. A.	1	1	0
Mutch, N.	10	10	0
Sidebotham, F. N.	5	5	0
Pollard, G. S.	2	2	0
Rose, P.	1	1	0
Fox, H. E. C.	1	1	0
Skelly, W.	1	1	0
Pendlebury, J. P.	2	2	0
In Memory of A. C. Clifford (H. W. Evans)	5	0	0
Parsons, J. E. H.	3	3	0
Brangwin, C. H.	10	0	0
Howard, Robert	10	0	0
†Ogilvie, W. H.	10	0	0
Owsley, G. Chetwode	1	1	0
Ticehurst, G. A.	2	2	0
Pitt, G. Newton	5	5	0
Davies-Colley, R.	30	0	0
Peile, H. D.	3	3	0
	£3,348	6	8

*First instalment on a/c of total contribution of £50.
†A further £10 promised as soon as possible.

Sum already acknowledged in GAZETTE (5/4/19)	£3,221	17	8
Subscriptions (details sent on 15th April)...	46	15	0
	£3,268	12	8

The Treatment of Scabies.

THE obvious disadvantages of the sulphur treatment of Scabies render any efficient alternative method acceptable.

This is to be found in the copper sulphate method which appears to be very little known. The patient is given a hot bath, during which scrubbing of the affected parts with a hand brush is carried out. He then dries himself and puts on some clothes—perfectly clean pyjamas—and waits for an hour, until the skin has resumed its normal state. He then strips and is painted over with a 4 per cent. solution of copper sulphate in water, care being taken to ensure that the interdigital clefts and other similar parts are not missed in the process of painting. He dries by evaporation in the sun or before a fire and replaces his clothes.

The painting is repeated daily for two or three days, after which he again bathes in hot water and clothes himself in a complete change. If the lesions are limited it is unnecessary to do more than paint the affected parts, but if they are very extensive with much excoriation from scratching, it is advisable to paint the body in sections—*e.g.*, arms and trunk one day, lower limbs, buttocks, &c., the next day, in order to avoid the slight risk of too rapid absorption of copper giving rise to poisoning.

Treatment of the pustular conditions resulting from scratching can be carried on simultaneously with—but preferably after—the copper sulphate treatment, and for this vigorous application of Unguentum Hydrargyri Oxidi Flavi, B.P., is the best. Occasionally fomentations may be required in various parts which have become more deeply infected.

To ensure a cure by this method, as with all others, steps must be taken to prevent reinfection from clothes and bedclothes. In the army this can be done by Thresh disinfection of blankets and outer clothes, and boiling of shirts, drawers, &c.

In civil practice under garments are similarly dealt with—outer clothes are reversed and ironed with a hot flat iron applied directly. Blankets may be ironed similarly, or exposed to air, and if possible to sunlight for at least three days. The advantages of this treatment are:—

1. Certainty of cure in a short time. If there is no reinfection cure results after three applications to any one part.

2. Avoidance of the irritation due to sulphur.

3. Avoidance of the grease and general messiness of the sulphur ointment method.

This is a point of very considerable importance in private practice, especially with female patients.

4. Simplicity of the method; which does not require intelligence from the patient or much time from the practitioner.

I have had considerable experience of this method in the army, and by it have treated successfully not only British troops, but also Macedonian Muleteers and Turkish prisoners, whose co-operation in cleanliness is not always easy to obtain.

H. WEBB.

Guy's Hospital Employees' Social Club

Rambling Section.

A ramble will take place on Saturday, May 3rd, from Northwood to Eastcote and Ruislip. All members and riends intending to come please meet outside Baker Street Station (Met. Railway) at 3 p.m. sharp. Fare 1s. 10d. return. Tea at "The Poplar" Tea Gardens, Ruislip, 5.45. A cordial invitation is extended to all lady members of the staff to join in this ramble.

Next ramble Saturday, May 17th, "Across the Surrey Downs."

J. H. E. WINSTON.
Hon. Secretary.

Cricket Club.

A general meeting of the Cricket Club was held on Tuesday, April 15th, at which Mr. Fagge presided. It was decided to revive cricket after a lapse of five years, and the meeting then proceeded to elect officers for the coming season.

Mr. Fagge, who was President before the war, was unanimously re-elected to that office.

Captain: D. M. P. Whitcombe.

Hon. Treasurer and Secretary: G. P. Lindsay.

Committee: C. Vincent Brown, J. R. Herbert (representing men in Dental School), C. H. C. Toussaint (representing men in the Dissecting Room).

The committee has power to co-opt one other junior member.

It was agreed to have a trial game early in the season, possibly on April 30th.

Specialities.

GLAXO.

Glaxo, as is usual on these occasions, will occupy very considerable space at the Nursing Exhibition at St. Andrew's Hall, Newman Street, W., on April 28th to May 3rd.

The Glaxo Rooms will be entered by the first floor on the right and will consist chiefly of a comfortable Rest-room for Nurses attending the Exhibition, where they will be able to meet their friends and find teas and refreshments.

A special feature of the Glaxo Exhibit will be a Cookery Demonstration of many of the Recipes which Nurses have sent in response to the Glaxo Recipe Competition. Nurses will have an opportunity of testing these Recipes and giving their opinion upon them.

Pass List.

Conjoint Board.

First Examination.

March, 1919.

Chemistry and Physics.

R. H. El Sawy
*C. W. Greenway
I. E. Harries
*M. Hawke
A. H. B. Heesom
J. L. Hopkins
H. C. Meathrel
D. W. C. Northfield
*C. T. Pomeroy
*R. M. L. Still
*C. W. Warne

*Physics only.

Biology.

H. P. Baylis
J. Dywien
I. E. Harries
D. B. Hitchings
S. A. Leader
W. F. Payne
D. G. Robinson
E. Sorabjee
A. Tom

Final Examination.

April, 1919.

The following candidates were approved in the undermentioned subjects, but are not eligible for diplomas.

Medicine.

G. A. A. Bradnack
J. V. C. Braithwaite
P. J. Briggs
M. Cohen
C. L. Curle
G. L. Cutts
A. K. Day-Lewis
K. M. K. Duff
W. G. Hay
R. B. P. Lansdown
C. Moffatt
S. Rose

Midwifery.

W. F. Attwater
W. M. Brown
H. G. Burford
A. C. M. Coxon
K. M. K. Duff
M. F. Ismail
G. P. Lindsay
C. M. Probert
G. K. Reeves
W. S. R. Thomas

Surgery.

R. C. B. Ledlie

L.D.S.

Preliminary Science Examination.

March, 1919.

Chemistry and Physics.—*Philip Domb, J. J. du Toit, C. H. Edney, S. T. Price, P. Krige, A. A. R. Madgwick, †H. K. Price.

*Physics only. †Chemistry only.

To the Editor, "Guy's Hospital Gazette."

Most Indulgent Editor,

May I even at this belated hour be permitted to add a few words to the dog controversy into which your politicians and physiologists have been led. In China we are dog experts, having produced the Pekingese by removal of certain internal organs from other dogs. Moreover, in some parts of our country dogs are an article of food—I speak with inside information.

Your politicians appear ignorant of the fact that experiments upon dogs are made every day by other dogs, and experiments upon men by dogs are as frequent, indeed more frequent, than experiments on dogs by men. According to your law a dog can bite a man with impunity. This is morally bad for the dog. And if you excuse the dog on the grounds of insanity, do you alleviate the symptoms of hydrophobia?

I agree entirely that the dog is most suitable for experimenting, and I cannot see what animal your politicians wish you to use. The buffalo and rhinoceros apart from the toughness of their skins to take up too much room in the laboratory, and I understand the housing problem is as grave with you as with us; moreover, there is the question of food. In most medical colleges the food is bad, but the accommodation of hoofed cattle and the heaviest variety of tusked quadrupeds could only tend to aggravate the difficulty. There are difficulties, too, in the way of the employment of such animals as the boa constrictor and crocodile.

The whole difficulty could be avoided by the proper choice of dogs. Any dog who was an honourable, upright animal should be exempt from experiments, but the nasty dog, or one who had already made experiments on man should be denied the protection of the law, with, of course, the right of appeal.

I am,

Your humble servant,

HO HO.

Births.

MAURICE.—On April 9th, at 47, Church Road, Hove, the wife of Harold Maurice, of a son.

HINDE.—On April 3rd, at Gurney Court, Magdalen Street, Norwich, the wife of E. B. Hinde, M.B., Ch.B. Cantab., of a daughter.

Death.

LEWIS.—On March 4th, Mr. E. C. Lewis, L.D.S., R.C.S.

Ed.—G. P. L.

GUY'S HOSPITAL GAZETTE.

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Passim.

RESIGNATION OF MR. COSMO BONSOR AS PRESIDENT OF THE HOSPITAL.

No words of ours can express with what regret one and all must have heard of the resignation of Mr. H. Cosmo O. Bonsor as President of the Hospital, nor a tithe of what Guy's owes to him. Mr. Bonsor was elected a Governor in 1882, Treasurer in 1896, and President in 1910.

On being elected Treasurer in 1896, he immediately set to work and organised the great Appeal for the Re-Endowment of the Hospital. The result of his sustained effort throughout the whole of his Treasurership and Presidency has been that not only have the Hospital finances been placed upon a sounder basis than could have been thought possible at the time of his election as Treasurer, but the most immense developments have taken place in every department of the Hospital and Medical School. We are unable to give in this article more than the barest account of what has been accomplished. The Re-Endowment Fund has now reached a total of £440,000, and the Hospital, which at the time of Mr. Bonsor's election as Treasurer was in very serious financial difficulties, is now free of debt. The average income of the Hospital, including appeals, during the fifteen years of Mr. Bonsor's Treasurership was £96,700 as against £44,000 during the previous ten years.

Amongst the many great advances that were made at Guy's during this period, the following may be especially mentioned:—The building of the Henriette Raphael Nurses' Home, the building and equipment of the present Out-Patient Departments. Many other works, including four new Operating Theatres in the Surgical Buildings and three new Operating Theatres in the Medical Buildings, the Bacteriological Department, Massage Department, and practically all the other special Departments. Numerous prizes and lectureships for students and nurses have also been founded during this period.

In a time of great adversity Mr. Bonsor devoted to the cause of the Hospital his means, time and capacity, his great influence, his wise powers of control and administration. We cannot express with what esteem Mr. Bonsor is held by all who are connected with Guy's. We know that throughout the period that he has been Treasurer and President his spirit has been a force that has led to the restoration of the fortunes of the Hospital.

THE following resolution has been passed by the Governors of the Hospital:— "Resolved that in accepting with sincere regret the resignation of Mr. H. Cosmo O. Bonsor as President of Guy's Hospital, the Governors in General Court assembled desire to tender him their cordial thanks and to express their deep sense of the distinguished and invaluable services he has rendered to the Hospital and Medical School as Treasurer and President for the past

23 years. Under his guidance the Hospital has maintained its highest traditions as a charitable institution for the treatment of the sick, and as a place of education and research. Notwithstanding the heavy expenses incurred in new buildings, renovation and development, Mr. Bonsor has succeeded in placing the Hospital and the Medical School upon a sound financial basis, and it is a cause for the greatest satisfaction to the Governors that though he is retiring from the high office of President they will still have the advantage of his counsel and assistance in the administration of the Charity to which he has given so much anxious and devoted care."

THE past fortnight has seen two honours conferred upon Guy's Hospital. In the first place we have to congratulate ourselves upon the election of his Royal Highness the Prince of Wales as President of the Hospital upon the resignation of Mr. H. Cosmo O. Bonsor.

The Hospital offers the warmest welcome to His Royal Highness to an office which was held by the late King Edward VII when he was Prince of Wales, and by His Majesty King George V. at the time when he was the Duke of Cornwall and York.

It was King Edward VII. who in 1896, as Prince of Wales, inaugurated the great campaign for the Re-Endowment of the Hospital, the astounding success of which has placed the Hospital finances upon a footing that the most optimistic could never have hoped for. As chairman at the great Festival Banquet and Reception held on the 10th June, 1896, by his personal appeal he stimulated a public interest in the fortunes of Guy's that has ever continued to bear fruit.

WE feel, too, that a great honour has been conferred upon the Hospital in the election of of Dr. Herbert French as Physician-in-Ordinary to the Royal Household. We heartily congratulate him and wish him the very best of luck in his new office.

WE would like to offer our heartiest congratulations to Dr. A. F. Hurst, who has been promoted Full Physician upon the retirement of Dr. Lauriston E. Shaw from the Active Staff; also to Dr. N. Mutch who has been appointed Assistant Physician.

WE are happy to announce that the Hospital has received a very generous donation from two Governors, amounting to £2,000, for enlargement and renovation of the Nurses' Cottage at Honor Oak Park and improvements to the garden.

WE are glad to draw the attention of readers to the Publishers' Announcements in the present issue of the GAZETTE. These announcements are of great value, not only to ourselves, but also, we feel fully justified in believing, to the publishers. The past half year has seen a record entry of new men to Guy's, the majority of whom must from time to time need new books, and these Publishers' Numbers afford an opportunity of placing before their notice all the standard text books and many valuable monographs. We should like to suggest to the Publishers that there could be no time more appropriate than the present for the publication of the standard works on Anatomy in the old terminology.

IT is with sincere regret that we have to record the retirement from the Active Hospital Staff of Mr. Wynne Rouw and Mr. C. J. Ogle. Mr. Wynne Rouw leaves us as Senior Dental Surgeon, having served on the Dental Staff over a period of thirty years. Mr. Ogle was on the Staff of Dental Anæsthetists for twenty-six years. He resigned in 1916, and was then promoted to the Consultant Staff. He continued, however, as Acting Anæsthetist on account of the war. The Hospital is deeply grateful for their long and valuable services. Their retirement is a loss which cannot easily be replaced.

A Course of Four Lectures on the Progress of Pathology will be given by Dr. A. E. Boycott, M.A., M.D., F.R.S., Director of Pathological Studies and Research, and Lecturer in General Pathology at University College Hospital Medical School, at the University College Hospital Medical School, University Street, Gower Street, W.C.

Lecture I., Monday, May 26th, at 4.15 p.m. —"The Regulation and Restoration of the Blood."

Lecture II., Wednesday, May 28th, at 4.15 p.m.—"Some Biological Aspects of Infection."

Lecture III., Friday, May 30th, at 4.15 p.m. —"Some Biological Aspects of Resistance."

Lecture IV., Monday, June 2nd, at 4.15 p.m. —"The Cause of Cancer."

Open to Medical Students and Medical Practitioners on presentation of their visiting cards. —G. Blacker, M.D., F.R.C.P., F.R.C.S., Dean

Appointments.

R.A.M.C.

Capt. C. Francis, R.A.M.C.(T.F.), M.B., B.S., F.R.C.P., M.R.C.S., has been appointed Surgical Specialist for Ear, Nose and Throat Diseases to the Rhine Army of Occupation.

Temp. Capt. A. J. Beadel to be Act. Maj. whilst commanding troops on a hospital ship.

Capt. W. G. Mumford relinquishes rank of Major on re-posting.

The following relinquish their Commissions (granted the rank of Lieut.-Col.)—Temp. Capt. C. D. Pye-Smith; (granted the rank of Major)—Major G. T. S. Sichel, Capt. J. F. Soothill, Temp. Capt. G. W. Smith; (granted the rank of Capt.)—Capts. W. K. Fry, C. Witts, J. Young, R. Curle, A. A. Greenwood, H. Chapple, C. H. Medlock, T. J. Killard-Leavey.

Capts. relinquishing the acting rank of Major.—G. G. Marshall, E. C. W. Starling, A. L. Shearwood.

Major and Bt. Lieut.-Col. S. L. Pallant relinquishes temporary rank of Lieut.-Col. on re-posting.

Lieut.-Col. C. R. Evans relinquishes acting rank of Colonel on re-posting.

Capt. J. A. Andrews relinquishes acting rank of Major.

Lieut. (Temp. Capt.) W. L. Panting to be Captain.

T.F.

2nd Eastern General Hospital.—Capt. (Acting Major) W. R. Wood relinquishes acting rank on ceasing to be employed.

2nd Southern General Hospital.—Capt. J. M. Fortescue-Brickdale is seconded for duty with Special Surgical Hospital.

Capt. E. P. Minett is seconded for duty under the Colonial Office.

Special Reserve.

Capt. J. Walker relinquishes acting rank of Major.

Capt. F. Cook to be Major.

R.A.F.

Capts. A. G. H. Moore and A. L. George are transferred to the unemployed list.

Civil.

To be Certifying Surgeons under the Factory and Workshops Acts.—S. C. Clapham, M.B., B.S. Durh. (Martock); J. H. Donnell, M.B., B.C. Camb. (Hinckley).

Papers by Guy's Men.

Major P. N. Vellacott, M.B., B.S., F.R.C.S. (T.C.): Spinal Injury with retention of Urine and the avoidance of Catheterisation.—*Lancet*, May 3rd, 1919.

Sir W. Arbuthnot Lane, Bt., M.S., F.R.C.S.: Disease and Chyme infection.—*Ibid.*

Col. G. S. Elliston, C.B., A.M.S.: The after care of tuberculous ex service men.—*Ibid.*

F. M. Holborn, L.D.S.: Chronic marginal gingivitis: its commonest causes.—*Brit. Dent. Journ.*, May 1st, 1919.

Discussion on the present position of spinal anæsthesia; *Proc. R.S.M., Sect. of Anæsth.*, March, 1919, Mr. P. P. Cole, p. 12; Dr. Shipway, p. 13.

E. L. Kennaway, D.Sc., M.D. Oxon: The occurrence of variations in the results of successive tests; the chemical application of the date.—*Lancet*, May 10th, 1919.

Lt.-Col. A. F. Hurst, M.D., F.R.C.P.: War contractions—localised tetanus, reflex disorder, or tetanus. *Brit. Journ. of Surgery*, April, 1919.

Pass List.

Conjoint Board.

FINAL EXAMINATION. *(cont.)*

Medicine.

St. G. B. D. Gray	E. R. Webb

Surgery.

St. G. B. D. Gray	W. K. McKay
L. Lyne	A. E. Sawday
S. Wolff	

The following gentlemen have now completed their examinations:—

St. G. B. D. Gray	A. E. Sawday
L. Lyne	E. R. Webb
W. K. McKay	S. Wolff

Notice.

ENTRANCE SCHOLARSHIPS IN DENTAL MECHANICS.

April, 1919.

(A) OPEN SCHOLARSHIP.

Mr. D. T. G. Dickens.

(B) PUPILS' SCHOLARSHIP.

Messrs. F. W. Day, J. J. du Toit, æq.

Guy's Hospital,
5th May, 1919.

Minor Diseases of the Outer Ear.

CLINICAL LECTURE BY T. B. LAYTON, M.S.

GENTLEMEN,—I want to talk to you to-day about a certain class of diseases of the ear which any one of you will be able to treat yourself if you will take a little trouble.

Persons come to those who deal with diseases of the ear for either one of two major subjective symptoms, those of deafness or pain: or with one of the minor subjective symptoms, a buzzing in the ear, or what they variously describe as irritation or itching. Or they come up on account of one or two objective symptoms, namely, either running from the ear, or a swelling of the pinna.

When a patient comes with the complaint of deafness, you look inside the ear, and, in a very large number of cases, you see that the auditory meatus is full of wax. I think we can profitably spend a few minutes in considering this question of wax in the external auditory meatus. It varies very remarkably in the amount, in the consistency, and in the degree of trouble it causes the patient. Whatever its condition, you have to get rid of it before you can see, or even attempt to see, the drum of the ear. And you get rid of it by syringing. When you are syringing an ear, there are two golden rules to remember. One is, that whatever your solution, you must use it at body temperature. If you use it either hot or cold, you will stimulate the vestibular nerve, and this will make the patient giddy, and may even cause him to fall on the floor and vomit. This is not serious, but the patient will not like it, and it is unnecessary if the solution is used at the right temperature. The other golden rule is, to syringe hard for wax, and gently for pus. Beyond that, I do not think there is anything I can tell you for your profit in the lecture theatre: you have to do these things yourself.

There are several other ways of getting rid of wax. One is taking it away with forceps, another using wax hooks. Personally, I do not think much of any of them; you generally hurt the patient by using them, and have to resort to syringing in the end. Sometimes you think you can easily remove a piece of wax with the forceps, but when you seize hold of it you also grip the fine hairs which are found at the entrance of the meatus, and the pain given by pulling them out does not help the patient's attitude for further examination. I advise you to trust to syringing only for the removal of wax. Sometimes the amount of wax in the ear is extraordinary: you get out a big block, and then think the ear is clear, but if you look, you see some more. You syringe again, and you get away as much as at first. Therefore look inside the ear to satisfy yourself that all the wax is out. Sometimes a patient comes and says his doctor syringed all the wax out a few days ago, but when you look inside you see there is still a large plug. When you have removed all the visible wax, gently mop out the external auditory meatus with a little pledget of cotton wool, so as to dry it. It is extraordinary what relief a patient has after you have removed a hard plug of wax. The late Sir Samuel Wilks, the great physician to this Hospital, is reputed to have said, in one of his cynical moods, that there were two kinds of ear diseases: the one which the ear surgeon cures, which is wax, and the other that the ear-surgeon does not cure, which is all the others! There is a considerable amount of truth in that. It is remarkable how a patient who has been seriously deaf, will be able to hear again when he has had wax removed. At the last hospital I was at before

I came home, there was a small, hopeless, idiotic orderly in the operating theatre, whom we converted into a respectable individual by getting the wax out of his ear: his folly and foolishness had been simply due to the fact that he was deaf, due to a tight plugging of his ears with wax, which had been there for years. He had been placed in "B" category simply on account of his deafness.

I want to give you one or two other hints about wax in the ear. Frequently one is told by a patient that he had his ears syringed a day or two ago, and that he suddenly became deaf afterwards. If you get such a history, it is almost certain that the trouble is wax. Frequently a dry plug of wax will cause no deafness at all, or only such a slight diminution of hearing that it does not trouble the patient at all. But when he gets the wax wet, it softens and swells up, fitting the external auditory meatus more tightly than ever, so that, from that moment, the patient is stone deaf in that ear, until the wax dries again. The other point about wax is, that sometimes there is inflammation of the external auditory meatus, a sort of dermatitis of the skin lining it after you have removed the wax, which is not surprising if you have done a lot of syringing. But it rapidly gets well if there is no complication underneath.

The next symptom which these people come on account of is pain. Pain in the ear is due to one of three things: (1) carious teeth; (2) acute inflammation of the middle ear; (3) furuncles in the external auditory meatus. When you can find nothing wrong with either the external auditory meatus or the drum, have a look at the teeth: it may be that one of the molars on the same side, either at the top or the bottom, is decayed. Have those teeth seen to and the earache will disappear.

The other two things which cause pain in the ear are inflammation of the middle ear, *i.e.*, acute otitis media; and furunculosis of the external ear. Sometimes furuncles of the external ear may be so severe, and make the patient so seriously ill, that you will mistake it for acute inflammation of the bone surrounding the mastoid antrum, and may be inclined to operate on it.

Acute inflammation of the middle ear is not the same as acute mastoid: the latter is a complication of acute inflammation of the middle ear. What the ear surgeon wants is to get hold of a case of acute inflammation of the middle ear before complications have occurred; it is what he is always on the look-out for, because he can do some good by puncturing the drum, under gas. If he does that he will, in the vast majority of cases, save chronic discharge of the ear, which goes on year after year, and may persist until some big operation is done, leaving the hearing destroyed. Therefore, we cannot be wasting time when I tell you anything about acute middle ear trouble.

In order to see the conditions I have mentioned, you must use the frontal mirror, and also have a bowing acquaintance with the otoscope. Do not be worried because you cannot see every patient's drum; you can do a good deal if you can only see half the external auditory meatus. But there are many people who are discouraged because they cannot make out the drum in every case. Until you have practised it, it is quite a difficult thing to see a drum, so try and learn to use a frontal mirror and the otoscope. When you see one of these cases, the patient may come for ear discharge as well as pain. Every discharging ear is not a case of acute middle ear disease with perforation of the drum. Quite a number of lesions of the external auditory meatus cause some dis-

charge from the ear, which the patient notices and tells you of. I told you at the beginning that this was an objective symptom, but I would advise you to look upon it as a subjective symptom until you have confirmed its objectiveness yourself. By that I mean do not take the patient's word for it, but look yourself. Sometimes it is only soft wax struggling out of the ear; sometimes it is a mixture of soft wax and moist epithelium, and a serous discharge from dermatitis of the external auditory meatus. Sometimes you see nothing but a heap of moist epithelium in the external auditory meatus. Before you can give any opinion you must get that clean, by mopping it out with a little wool on a wool-carrier. You must be very gentle and patient about it. If the middle ear is inflamed, it is acutely tender, and if the patient has got a furuncle of his external auditory meatus, it is frightfully tender. If there is dermatitis, that also is very tender. You cannot do anything with a person subject to these things unless you are very gentle and patient. What I have been using recently for mopping out ears I learned on the desert, where there were many things we could not procure. I refer to ordinary petrol. It is a solvent of wax and of fat, and it quickly removes a sticky mass of pus, epithelium and wax. So far as I know at present, it does no harm; it does not cause irritation, nor hurt the patient. It also has the advantage of making the little hairs at the orifice of the meatus lie flat. You then try and get a look at the drum. If you cannot see it, there is probably some swelling of the skin lining the external auditory meatus; and that favours it being furunculosis. Sometimes you can see a furuncle.

Inflammation of the middle ear, by itself, is not tender over the mastoid; it only becomes tender when the inflammation has spread into the mucous membrane lining the mastoid antrum, and from that to the surrounding bone; that is to say, when it has become a mastoiditis in addition to otitis media. But all these lesions of the external auditory meatus are most tender. Therefore, in your examination you must be most careful to decide between the two.

When you are examining for tenderness in the ear, do not hit a man on the mastoid. Place one hand firmly on the top of his head, and press the mastoid bone with the other, and while you are doing that, do not ask him anything at all. If it is tender, you will at once feel a movement with the whole of his body in the direction of the hand which is on the top of his head. In distinguishing between a mastoid condition and otitis externa, you must press on one thing or the other, but not on both. Many people press so that their finger is touching both mastoid and pinna. That is of no diagnostic value at all. To examine for tenderness of the mastoid, you must press directly inwards, taking care that the index finger is not touching the pinna. To examine for otitis externa, press on the pinna from below, pushing upwards and forwards. If there is tenderness when you press on the bone, you may practically be certain that it is not the external auditory meatus, unless the inflammation has gone on to such a degree that there is a lot of œdema over the mastoid area which is due to disease of the external auditory meatus. If you find there is tenderness when you press the pinna, you may be certain that it is due to inflammation of the external ear, either of the pinna, or of the external auditory meatus. That does not absolutely exclude middle ear disease and its complications, because in acute mastoiditis the inflammation may spread forwards to the outer ear.

Let us return to the question of furuncle. We will imagine you have cleaned out the ear, and that you have seen a small boil somewhere

in the external auditory meatus, generally on its floor. I think the best thing to do is to open it at once, either without an anæsthetic or with gas. They are so very tender that if it is anything more than a small one you had better use gas. I do not think cocaine is of any use at all for the outer ear; it seems to have no effect beyond a psychological one. I favour opening them as soon as they are seen, whether they come to a head or not. You may thus save them coming to a head, and you will save the patient much pain. After opening, put a little gauze in for 24 hours, and apply heat to the outer ear. That may be done in the form of a fomentation; but as the patient will probably want to lie down after his little operation, you will find heat is best applied by a hot water rubber bottle, on which he lies. But the bottle must be covered by flannel. I think it is well to keep drops away from that ear; and, unless there is profuse discharge, use some simple application, such as Ung. Hydrox. Flav., which you put in yourself. You know how difficult it is to get boils on the back of the neck well; you may get one well, and another comes. The same is true of boils on the ear.

Short of furunculosis of the external ear, there are a considerable number of cases of dermatitis. My attention was first drawn to this in the desert. We came up just short of Gaza, and went into camp on the sea coast, where, in the middle of July, everyone was revelling in sea-bathing; men were bathing three and four times a day when allowed. During that time I saw an enormous number of cases of furunculosis and dermatitis of the ear in the Division. We were then shifted from the coast to a point further inland, and were on a ration of water of a gallon per man per day, which does not allow much for washing purposes. Then these cases of furunculosis and dermatitis entirely stopped, except in officers; in other words, in those who were able to do more washing of themselves. The other cases I saw were those in which medical officers had syringed ears because there was irritation. The point is, in fact, that on which Sir Cooper Perry used to insist: dry dust will not irritate the skin, wet dust does. The dry sand of the desert did not cause irritation in the ear, although all ears were more or less full of sand; but when that sand in the ear was wetted by sea-bathing, or by washing, or by syringing the ears, dermatitis commenced at once. It is an important point to remember, because you may find the same thing in civil life.

Another thing which causes this dermatitis is, I think, external dirt. In the army I have seen several cases of severe inflammation of the external auditory meatus, with quite a lot of impetigo of the external ear, which had been diagnosed as acute otitis. They were due, I think, simply to the fact that either the man had omitted to, or had not been able to, keep himself clean. Our own mess cook was a case in point. He was a very good cook, and we did not want to lose him. But when he came into the army he had acquired the idea that it was a right of the cook to remain dirty because his work sometimes made him dirty. He started an impetigo, and that went on to acute otitis externa, with profuse pus. I am certain he never had otitis media, but we had to evacuate him to the base. He was treated there as otitis media, and was nearly having a mastoid operation done. The state of his ear was such that one could not see down to the drum.

Now with regard to treatment of dermatitis of the external auditory meatus. The first thing to do is to get the ear clean. That is necessary because you cannot distinguish it from otitis media until you have got it clean.

Even when you have, it is sometimes very difficult to tell, because the dermatitis involves not only the cutaneous funnel going down to the drum, but also the outer layer of the drum itself. And there may be bullæ on the drum, which are very difficult to distinguish from a bulged drum of acute otitis media. You will remember that when you are treating dermatitis of the skin you generally tell the patient not to wash: that is, wet must be kept away from it. Acting on that principle, I have recently been trying to get something with which I could treat these cases of dermatitis of the outer ear without using aqueous drops. I have had an ointment made up, consisting partly of lanoline, partly of glycerine, and with a little antiseptic in it, because both lanoline and glycerine are hygroscopic, and I thought they would absorb the moisture and so keep the ear dry. Unfortunately when we mixed them together the result was a putty-like mass, and we could not do anything with it. But in a number of cases I have had success with pure glycerine drops. The cases which do not get well with these drops are, I think, those in which I have made a wrong diagnosis and there has been some otitis media in addition.

The last thing I want to talk to you about is otitis externa, compared, not with the acute otitis media in which there is bulging of the drum, which requires puncturing, but with the chronic otitis media in which the drum has been destroyed, and there is an inflamed middle ear discharging pus which is pouring over into the external auditory meatus. There are a number of cases going about which are being treated as ordinary discharging ears, under the belief that they are old acute middle ears which have become chronic, but are nothing but dermatitis of external auditory meatus. Such a dermatitis may become a complication of middle ear disease, because the pus secreted by the middle ear pours out into the outer ear, and in flowing over the skin constantly irritates it. When I say it is the pus, I am not so sure it is that so much as the drops which are instilled, especially when they are spirit drops and zinc sulphate added. It is a very difficult matter, for the mucous membrane is full of granulations for which you want to use a stimulating lotion, such as red lotion, and you pour this over an easily irritated area of skin. You may keep up an external otitis by continuing with drops long after the middle ear has got well. A child comes up with his discharge going on as bad as ever, and there is a tendency to say "go on with the drops." You must review those cases every little while, carefully mopping out the ear to see the condition of the middle ear which is underlying the external trouble. If you find the middle ear has practically got well, but the external ear is seriously inflamed, it is almost certain that the drops were responsible, and you must change them. If you mop it dry and paint it once with Hydrox. Flav., or let it remain dry for a time, in many cases it will get well right away.

Let me now briefly summarise the points we have been over. You must acquire a bowing acquaintance with the frontal mirror and the otoscope. Secondly, in your ordinary training you must keep in your mind the kind of cases which you can treat yourself; and you must be suspicious of the existence of some more serious disease. The standpoint is the one I took up in regard to eye diseases when I was up the line. I would not dream of touching a serious case of eye disease, but, as a result of having been Mr. Ormond's dresser, I do know enough about them to understand what case I can treat myself, and, when I ought to be suspicious of a serious condition, which requires to be dealt with by somebody else. That seems to

me to be the right attitude with regard to every specialty. With regard to ears, you can certainly deal with wax. If you do that, you will certainly save great trouble and prevent a lot of people coming to hospital out-patients and to special departments. Secondly, when a person comes with pain in the ear, with or without discharge, you must consider whether it is acute otitis media, with or without the complication of acute mastoiditis, or whether it is merely furunculosis of the external auditory meatus. The latter is easily treated, and the pain soon relieved. The otitis media is also easily treated; and one drum punctured in a state of acute otitis is better than ten big operations at a later stage done to save life, after the sinus has become thrombosed.

On the Preservation of the Prepuce.

"There's a divinity which shapes our ends,
Rough-hew them how we will."

Nature is a lady for whom most have considerable respect, and not least among her many virtues are her extreme economy, and her tidiness. She resolutely refuses to waste time and energy in manufacturing structures for which she can find no use; and if she finds that any of her products are becoming out of date, she invariably scraps the lot. We see this in the human body in the atrophy of the muscles of the ear, in the very small representative of the nictitating membrane, in the complete disappearance of the branchial clefts, and in a hundred and one other things with which morphologists and anatomists persecute us.

But although Nature compels almost universal admiration, some members of our profession seem to have a marked antipathy to her. They are always endeavouring to prove that she is wrong. Needless to say, Nature ignores their outcry, and they, like many others so ignored, resort to brute force. In individual cases brute force always wins. In the species, Nature invariably triumphs.

Now within the past few years these anti-naturalists have been reviving a very old argument. Long, long ago, when man had not yet emerged from the brutes, Nature, careful mother that she was, observed that in her latest children, the mammals, the glans penis was an extremely tender and delicate piece of anatomy. With characteristic care she made a covering for this part, the prepuce. Then man came, and for thousands of years lived happily, never doubting that what Nature had given him was for the best. But a certain sect arose who denied the unerring wisdom of their mother, and made a law that all their male babies should be circumcised. They were very bigoted in their views, but Nature was more bigoted still. The faster they cut off prepuces, the faster did Nature produce babies with prepuces intact. The argument went on for thousands of years, and ended by one of the leaders of the anti-naturalists, St. Paul, giving in. And until quite recently, no one has ever had the courage to start the controversy again.

However, as we have remarked above, some members of the medical profession have attempted to restart the conflict. At present there is quite a craze—even within the sanctuary of Welfare Centres—for removing normal babies' prepuces. Yet it is difficult to find an adequate reason for this exacerbation of barbarous arts. It is not the fault of the teachers of surgery. A modern, well-known text book of surgery states that children, *above the age of infancy* in whom the prepuce cannot be retracted, should be circumcised. Why, then, does the infant of a week old or younger have his prepuce ruthlessly removed? Can it be that he suffers from enuresis at this advanced age?

Or has he already started vicious habits? (Some think that these are indications for circumcision.) Certainly he has seldom any difficulty in passing water. Let the operator nurse him, minus a napkin, and see (a mackintosh apron is recommended for this experiment). There is rarely any indication of balanitis. True, his prepuce cannot be retracted, but this is a normal condition at this age.

It is impossible to think that medical men advise operation merely for their own pecuniary benefit, regardless of the sufferings of their tiny, inarticulate patients; similarly, no youthful operator, we are sure, would be so callously keen as to perform the operation merely for the sake of experience. No, the chief reason, we are convinced, is that many men qualify without any but the crudest knowledge of babies. The mother says that her baby screams during micturition. The doctor advises circumcision. If questioned, the mother will also probably say that the baby screams when passing motion or flatus; we suppose that some people would recommend excision of the anus. If, on the other hand, the doctor could recognise the nervous, restless infant who belongs, according to some American and British physicians, to the neuropathic diathesis (*pace* those who object to the last word), he would know that circumcision would have no effect, whereas, a judicious teaspoonful of Haustus Chloral Infantum, together with a heart-to-heart talk to the young and inexperienced mother, would work wonders.

Now let us consider some of the drawbacks to the operation. The sensitive glans is exposed—inflammation is almost a certainty. A scab forms over the meatus—the infant screams with good reason when micturition dislodges it. In older children the patient is constantly reminded of the existence of his external genitals, and bad habits may be formed. The ordeal of dressing forms the nucleus of night terrors of unimaginable horror to the sufferer, and implants in him a deplorable fear of the medical profession as a whole.

Perhaps the day will come when, before circumcision is decided upon, a thorough weighing up of pro's and con's will be made, and if something must be done, a little manipulation with a probe will first be tried. Fifty years is the longest experience a medical man can hope for. Nature has had an experience of six million years; is it not possible that she knows best?

V. B.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—I have just received a welcome copy of the GAZETTE (dated January 25th, 1919), and to one in the wilderness it comes even more "grateful and comforting" than in England.

I was much interested in Mr. Turner's case of "A Fall from a Cliff 320 ft. high without Fatal Injuries." I put forward the suggestion that possibly one factor in the man's immunity from death, instantaneous or late, and from permanent disablement, may be atavistic. A savage can fall with greater impunity than a civilised man. A drunken man or a sleep-walker recapture some of this impunity. Perhaps, in this case, the man, from whatever cause, was in a somnambulistic state, and in his fall had, atavistically, some of the immunity from serious injury of man in the savage state.

The parallel case—"E. H. L."—which Mr. Turner gives us, also perhaps supports the above suggestion, in that a child is obviously less highly educated physically than an adult, and so is nearer the happy state to which our acrobats, and, to a less extent, athletes, can attain only after a long course of physical training, which last is, after all, only re-educating one's self on the plan which a savage, from necessity, adopts.—Yours,

T. L. HEATH,
Capt. R.A.M.C. (S.R.).

Attached 32nd Lancers,
Mesopotamia.

SIR,—I wish to thank you and all Guy's graduates of London University in Convocation, for the support given to me in the recent election to the Senate of London University to the vacancy created by the retirement of Prof. Sir Thomas Barlow, in which I had the honour to be successful.—I am, yours very faithfully,

THOMAS L. LISTER.

31, Harley Street, W. 1.
May 10th, 1919.

The Treatment of Compound Fractures and Joint Wounds of the Upper Limb.*

Hunterian Lecture delivered at the Royal College of Surgeons).

BY E. G. SLESINGER.

IN considering the treatment of projectile wounds of the upper limb, the infinite variety of the lesions that present themselves makes the description of the detailed technique employed in individual cases of relatively small value. Consequently it is proposed in the present place to discuss rather the general principles underlying the treatment of these severe injuries, more particularly those early stages of treatment, which, during the war, were carried out at the Clearing Stations and Base Hospitals in France. Perhaps one of the most valuable lessons of war surgery has been that which these severe compound fractures have taught, and though fortunately their occurrence under conditions of peace is infinitely less frequent, yet their treatment in the future will undoubtedly benefit greatly from the improvements which the necessities of war have brought about.

The fact that compound fractures of the femur have been associated during the war with a very considerable mortality, has led to their receiving rather special recognition, and by contrast, injuries to the upper limb have been treated along perhaps less progressive lines. None the less, the functional and economic disabilities that too often result from these injuries, and their importance both to the individual and to the State, should lead to greater and greater endeavours to improve those early stages of treatment on which final results so largely depend. It has seemed best to deal with the subject under discussion under two main headings, firstly, methods which are suitable in the early hours of the injury and whose object is the conversion of a compound into a simple fracture by excision and suture, and secondly, methods which have been used when for any reason sepsis has set in.

Under war conditions the first of these groups has usually been undertaken at the Casualty Clearing Stations, and the second group at the Base Hospitals, so that in considering the splinting of early cases, a period of transport has to be taken into consideration. In the base hospitals, on the other hand, the most suitable splint could be used, regardless of its applicability for transport purposes, and it is these splints that should be used in dealing with civil cases where the necessity for transport does not arise.

In any injury of the upper limb it is generally and rightly maintained that amputation should never, under almost any circumstances, be considered except as a life saving measure, at any rate in the early stages of treatment, and the superiority of the worst natural arm over the best artificial one should make the most conservative surgeon more conservative still.

Function in the upper limb represents the main objective of the surgeon, as does stability in the lower, and when it is recognised that only by the speedy elimination of sepsis and the early restoration of movement to every remaining joint and muscle in the limb can function be adequately regained, a good deal of preventable crippling will be avoided, and the patient will be saved long and weary months of most trying orthopædic treatment.

*By kind permission of the Editor of the *Lancet*, in which journal an abstract of this lecture has previously appeared.

PRIMARY SUTURE.

The primary excision and suture of wounds, which has been so successful during the last two years, has improved results enormously, the chief factors in success being apparently, firstly, the time which elapses before the patient reaches the operating table; secondly, the anatomical possibility of complete excision of all injured tissues; and thirdly, the condition of the main blood-vessels of the limb. As regards the first factor—under war conditions—it is unfortunate that in this group of injuries the patient is very often a "walking case," and in consequence of his good fortune in this respect he suffers by the increased interval between the receipt of his wound and his arrival at the operating unit.

In *injuries without fracture*, the whole track can usually be excised "en bloc" and in that case the question of whether immediate or delayed suture shall be performed will depend chiefly upon whether the case can be retained and watched for at least 7 to 10 days, or whether he must be evacuated forthwith. When suture is performed, however, an attempt should be made to restore as far as possible the functional anatomy of the limb, torn muscles being united or grafted into others of the same group, intermuscular compartments and tendon sheathes being restored where possible and particular attention being given to repair of the deep fascia, since omission to deal with this structure leads to adhesions of the scar and consequent troublesome disability. Where a careful previous examination of the case is possible, it will usually be evident before operation which nerves are out of action, and these should be traced and united wherever the nature of the injury permits. Even if ultimately the wound should pursue a septic course, such early union of divided nerves will prevent subsequent retraction and will greatly facilitate later reparative operations.

In many injuries by either shell or bullet, the wounds of entrance and exit through the skin are often disproportionately small in comparison with the extensive nature of the muscular damage, and these cases in particular call for very careful and extensive excision. Further, extensive muscular hæmatomata, or even a diffuse infiltration of the whole limb with blood, may be found, depending on the size of the vessel which has been injured. All such blood-clot should be carefully turned out, and if the actual bleeding point cannot be tied, as for example, occasionally in the upper forearm, the main vessel should be ligatured above, sufficiently high to control the bleeding. Both artery and vein should be tied, since as Sir George Makins has pointed out, gangrene is more likely to follow ligature of the artery alone than ligature of both vessels. In such cases closure of the wound should be delayed for at least 48 hours, or until the danger of a sudden acute infection in the wound is past, and care must be taken to keep the limb thoroughly warm, particularly where it is immobilised in a Thomas splint.

If these uncomplicated wounds are at all extensive the limb should be splinted as carefully as if a fracture were present, as immobilisation undoubtedly enables any remaining sepsis to be more readily dealt with.

I do not propose to enter in any detail into the vexed question as to whether any antiseptic substance should or should not be left in the wound after excision. So much has been written on this subject, and so many facts have been proved and disproved by equally competent observers, that the student of the truth is left rather bewildered by the clashing of the test-tubes and the conflict between different inter-

pretations of the same facts. In these early excisions, at any rate, there seems little doubt that an almost similar percentage of successes can be claimed by surgeons using different antiseptics, or none at all. It would appear rather that those surgeons who do *not* use these substances claim complete and thorough surgery as the cause of their success when such attends their efforts, and would maintain that the equally good results which are obtained by those who *do* use antiseptics are due to the efficiency of their surgical procedure, and that they, in their modesty, rob themselves of the credit they deserve by laying it at the feet of some of the much vaunted and many coloured antiseptic substances in use.

Where primary suture is practised, heat, either in the form of fomentations, or as electric or hot air baths, is of undoubted value in after-treatment, and an additional point to be noted is that in these projectile wounds the whole process of repair tends to be somewhat sluggish, and sutures should be left in place at least 12 to 14 days, as otherwise troublesome gaping is likely to occur on their removal. In watching these cases after suture, the surgeon is often apt to undo a perfectly successful piece of work by removing his stitches on the indications of the temperature chart. Temperatures of 101° or even 102° or 103° are not at all uncommon after successful excisions, and the pulse rate and the local symptoms of the wound form the only reliable guide to interference.

Wounds Complicated by Fractures.

If these cases can be operated on sufficiently early as great a proportion of successes can be hoped for from excision and suture as in the case of wounds of the soft parts alone. The same general principles of excision of all damaged tissues apply, though it is usually impossible in cases of fracture to excise the whole wound *en bloc*. In the upper limb, where the speedy conversion of a compound into a simple fracture is all important, and where function is even more essential than strength, a more radical removal of bone fragments is justifiable than in the case of the lower limb.

In this connection the French surgeons practise a most extensive removal of all loose or even partially loose fragments in their "debridement" operations, while the tendency of English surgery is to leave any fragment which may possibly live in situ. In most fractures of the upper limb a middle course is perhaps best, but all completely loose fragments should usually be removed, since not only are the chances of primary union improved thereby, but the formation of an involucrum is avoided, which, particularly in the forearm or hand, is often very disabling. An exception should be made in the case of fragments bearing a portion of an articular surface, since the disability attending their removal usually justifies the risk of their retention, except in certain places to be mentioned later. The cleansing of the ends of the main fragments can generally be satisfactorily performed with a sharp spoon, though if there is no great loss of substance the removal of a thin layer from each end is, perhaps, safer.

It must not be forgotten in dealing with these presumably already infected cases, that the dangers of additional sepsis being introduced by the surgeon are in no degree less than in operating on a simple fracture, and no precautions to avoid such secondary infection should be omitted. Long forceps for manipulating the fragments render the use of the fingers unnecessary in most cases, and a careful technique will well repay the extra time involved.

Fractures of the Humerus.

This bone is particularly favourable for treatment, on account of the comparative ease with

which it can be reached and dealt with, and the wide muscular excisions that can be performed, and partly on account of the rapidity with which it throws out callus even after very extensive loss of substance.

In fractures of the shaft, after excision has been performed, the limb has usually been put up in extension in a straight Thomas' splint, with a swivel ring for transport purposes, but where that is not necessary it would be better to adopt the suspension extension splint which will be described later. If the straight splint is used the limb should be kept quiet in this for at least a fortnight, after which gradual movement may be begun. In the upper third of the humerus, if excision has proved possible, position during transport has usually been best maintained in a Thomas splint without a swivel ring, and with the arm at right angles to the body.

Fractures of the lower end of the shaft are often very difficult to deal with, and in the later infected stages a good many cases are seen where very considerable disability has resulted from the malposition in which they have been allowed to unite. The almost invariable trouble is the forward tilting of the upper end of the lower fragment, which is accentuated by the straight Thomas splint in which they are often put up. Where excision and closure can be performed, the most satisfactory result in such cases seems to be obtained by putting them up in extreme flexion, as for a separated epiphysis, and steadying the line of the bone by means of an acutely flexed internal or external angular splint with a long upper limb. In all compound fractures of this bone, the action or inaction of the musculo-spiral group of muscles should be carefully examined before operation if possible, and if apparent paralysis is present the musculo-spiral nerve should be examined and repaired if necessary and feasible. Dorsi-flexion of the wrist must be maintained in any after fixation, and if the nerve is found to be anatomically injured, it is sometimes a good plan to maintain such dorsi-flexion during the processes of repair by the excision of an eliptical portion of skin on the back of the hand followed by linear suture, as described by Sir Robert Jones in the treatment of infantile paralysis affecting the elbow flexors.

Fractures of the Forearm.

Where only one bone of the forearm is fractured, free excision of the infected ends can usually be practised, and especial care must be taken to reconstitute as far as possible the contour of the bone, in order to obviate the troublesome adhesions of tendons which so readily follow irregular callus formation in this region. The middle third of the radius presents special difficulties, and unless the pronator radii teres can be made to act as a splint, the attainment of anything like perfect position is often difficult or impossible.

In injuries to the upper end of the radius where the fracture involves the articular surface, as it so frequently does, it is often best to excise the head of the bone at the primary operation. If movement is begun early in these cases, very good results can be obtained, while where a more conservative practice is followed considerable disability often results. With fractures of *both bones*, particularly where loss of substance is at all extensive, there are often great difficulties in treatment.

In the first place the numerous tendons prevent a satisfactory excision of the soft parts, while, as regards the bones, the maintenance of good position and the prevention of cross union, particularly where the fracture includes the radius in its middle third, is extremely difficult.

Care should be taken to reconstitute as far as possible the mesial surfaces of the bones, and the fragments projecting in this plane should be removed if they cannot be re-adjusted. In forearm fractures that have been excised and where speedy transport is necessary, a swivel-ring Thomas arm splint has been used, with extension obtained by a glove glued to the hand, though where transport is not a necessity better position and earlier movement can be obtained by using the so-called suspension extension splint. Extreme supination must be kept up, and where a Thomas splint is used, a very convenient method of securing this is by a tennis ball placed in the palm and secured to the bars of the splint in the required position by threads sewn into its outer coat. A tennis ball, or some form of wooden ball splint is also best used in dealing with fractured metacarpal bones, providing the palmar wound, if one exists, has proved capable of being closed. The transverse and longitudinal arches of the hand—the former bony and ligamentous and the latter bony alone—have received far less attention than their importance deserves and in many cases of inefficient splinting of the hand, either for injuries elsewhere in the limb, or more particularly for fractured metacarpals, the condition of "flat hand" which results is very crippling. In such a hand not only is the opposing power diminished or absent through the loss of tension in the transverse arch, but where the metacarpals have been improperly aligned, the absent longitudinal bony arch throws the metacarpo-phalangeal line of joints backwards and puts the interosii at a great disadvantage in their action.

When phalanges are fractured even very extensive damage can be dealt with without amputation by careful surgery of the wound followed by adequate splinting, and fingers that before the lessons of the war had been learnt would have been lost, can be saved by careful conservative methods. In these cases again, however, it must not be forgotten that perfect resumption of all normal functions is the essential object of treatment—and that it is not sufficient to heal the wound or repair the bone, unless the movements which are the raison d'être of the finger can be restored.

Extension is readily maintained in the early stages by Sinclair's ball splint with extension by means of a glued glove finger. In cases where the extent of the damage makes the application of a glove finger impossible, Sinclair's ingenious suggestion may be followed and traction obtained by boring a hole through the free end of the nail and using the nail for the transmission of the necessary pull.

(To be concluded.)

Change of Address.

W. E. Tanner, M.S., F.R.C.S., Guy's Hospital, S.E. 1.

Capt. T. Y. Moore, R.A.M.C., 17, Church Terrace, S.E. 13.

P. P. Cole, M.B., B.Ch., F.R.C.S., 15, Harley Street, W. 1 (Tel. Mayfair 438).

C. E. S. Morton Palmer, M.D., B.C., 103, Marine Parade, Worthing.

L. Mandel, M.D., from H.M.S. *Victory*, to 15, Upper Wimpole Street, W. (on demobilisation).

R. Felton, M.B , B.S., returning to Sooke, Vancouver Island, British Columbia.

Hedley Visick, 34, The Goffs, Eastbourne.

Capt. Cyril Francis, M.D., B.S., R.A.M.C., from 23 C.C.S., B.E.F., to 44 C.C.S., Cöln Germany.

M. E. Hutton, Powerscourt, Bournemouth, Hants.

George F. Stebbings, M.B., B.S., Brigown, 20, Telford Avenue, Streatham Hill, S.W. 2.

Miss K. I. Richardson, 15, Salcombe Gardens, Clapham Common, S.W. 4.

Surg. C. T. Helsham, R.N., R.N. Hospital, Haslar, Hants.

Guy's Hospital Chapel.

Report for the Year 1918-19.

The Rev. G. T. Charlesworth, Senior Acting Chaplain, left us on January 13th, 1919, carrying with him our gratitude for his devoted service here, and our best wishes for his new charge as Rector of Byfield, Northants. The Rev. W. Waller arrived on the same day, as appointed by the Bishop to carry on the work temporarily in Mr. Charlesworth's place.

Among our helpers in Chapel. Nurse Mummery, who had the care of the altar rails, has left us to join the Universities Mission to Central Africa, on which we earnestly wish her God-speed.

We regret the long absence through illness of Nurse Merton, who shared this charge with her. Nurse Townshend is undertaking it in their place.

We have also lost the services of Nurses Dewdeney and Verinder (in charge of the altar ornaments and ornaments boxes), and of Nurse Bentham (in charge of the small lectern); these have been succeeded respectively by Nurse Jamieson and Nurse King. Nurses Playle and Lane have joined Nurse West in the care of the big lectern. Nurse Baily has succeeded Nurse Mummery in choosing the hymns.

We sincerely thank Nurse Binning for her handsome gift to the Chapel of a white burse, made by herself from silk which came from the royal palace at Pekin.

With the sanction of the House Committee, new hymn-books and daily office books have been provided for the Chapel; many of the old hymn books have been distributed in the wards.

Our Thanksgiving for the Harvest was held on Sunday, October 6th, the special preacher at Evensong being Rev. C. Marsh Roberts, Assistant Curate of Christ Church, Westminster.

On Thursday, November 14th, three days after the signing of the Armistice with Germany, a short service of thanksgiving was held in the Chapel at 12.20, especially for medical students. On the Sunday following we took our part in the Nation's Thanksgiving. Celebrations of the Holy Communion were held in the Officers' Ward and Bright Ward, in addition to the usual Chapel services; and the appointed order of service was used at morning prayer. It added to our joy that Rev. A. E. Popham, C.F., M.C., our former Acting Chaplain, was able to celebrate for us at 8.45.

Two Memorial Services have been held in the Chapel during the year: on June 12th, 1918, at 12.30, for Mr. Dunn, who passed away on the scene of his long and devoted labours, and on February 20th, 1919, at 7.40 a.m., for Nurse Renira Chevalier, and Ruby Stevens, wardmaid.

On Tuesday evenings in Advent, special services were held as usual at 8.15, when the preacher was Rev. M. E. Attlay, Vicar of St. Matthew's, Westminster.

Our Chaplain, the Bishop of Southwark, whom we were glad to see restored to health, preached, according to his custom, on Ash Wednesday at the evening service.

At the special Tuesday evening services in Lent the preachers were Rev. A. Amos, Vicar of St. Paul's, Deptford, and Rev. W. C. Roberts, Vicar of St. George's, Bloomsbury.

Two Confirmations have been held in the Hospital by Bishop Cecil Hook: on December 21st, 1918, when two patients were confirmed in Miriam Ward at 2.30, and two wardmaids and two laundrymaids in the Chapel at 3; and on April 5th, 1919, in the Chapel at 3, when the candidates were one patient from Astley Cooper Ward, and three laundrymaids.

Chapel Fund Account.

Statement of Receipts and Payments for the Year ended December 31st, 1918.

Jan. 1. *Receipts.*			£ s. d.
To Balance brought forward from 1917 A/c			14 3 6
Dec. 31.			
To Offertories, &c.—			
Chapel	57 1 11		
Bright Ward	8 15 9		
Boxes, &c.	3 13 6		
		69 11 2	
„ Miscellaneous		0 18 0	
		£84 12 8	

Dec. 31. *Payments.*			£ s. d.
By General Account—			
Floral Decorations, &c. ...	12 14 11		
Books, Printing, Music, &c.	3 2 0		
Furnishing and Sundry Expenses	9 5 1		
		25 2 0	
„ Special Offertories—			
Metropolitan Hospital Sunday Fund...	3 13 4		
S. London Church Fund ...	4 19 3		
King George's Fund for the Wounded	4 11 0		
Maternity Samaritan Fund	7 7 7		
		20 11 2	
„ Balance carried forward—Cash at Bankers...		38 19 6	
		£84 12 8	

Audited and found correct,
April 4th, 1919. W. J. CURRY.

Births.

DUNDERDALE.—On May 4th, at 27, Riverview Gardens, Barnes, S.W.13, to Geoffrey Dunderdale, M.D. (Lond.), R.A.F. and Mrs. Dunderdale (née Quin) a son.

CROFTS.—On April 18th, at High Street, Windsor, the wife of Dr. Douglas Crofts, of a son.

Marriages.

COCKS—SHAW-ALLEN.—On Wednesday, the 30th April, at Southwark Cathedral, by the Rev. F. R. Cocks, M.A., assisted by the Rev. Arthur Hamp, M.A., Wallington, Surrey, Gilbert Anderson Cocks, second son of the Rev. F. R. and Mrs. Cocks, Upton, Horsell, Woking, to Gladys May, youngest daughter of Mr. and Mrs. Shaw-Allen, Tettenhall, Wolverhampton.

HARDY—SLY.—On April 30th, at the Chapel Royal, Savoy, by the Rev. Hugh B. Chapman, Capt. George Francis Hardy, M.C., R.A.M.C., son of Mr. and Mrs. G. A. Hardy, Cheshunt House, Champion Hill, S.E., to Eva Kathleen, daughter of Mr. and Mrs. H. Sly, 26, Quex Road, West Hampstead.

Death.

STEELE-PERKINS.—On April 18th, Arthur Edward Steele-Perkins, L.D.S., of Dawlish and Teignmouth, after a very short illness, aged 39 years.

Ed.—G. B. D.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 806] MAY 31, 1919. [SIXPENCE.

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Passim.

IN another page we publish a very interesting paper read before the Pupils' Physical Society on May the 1st by Dr. A. D. Marshall on the subject of the Application of War Surgery to Hospital Practice. The paper and the discussion that ensued may quite well have far-reaching results at Guy's, for it made clear a vitally important fact, namely, that immediate resuscitation is the first and most vital necessity in a patient suffering from shock, that it is best to delay operation until a considerable improvement in the condition of such a patient is evident.

Upon the suggestion of Dr. Marshall and other speakers at the meeting steps have already been taken to provide a much closer application of this principle at Guy's than has been the rule in the past. In the first place, the Front Surgery will shortly be provided with a radiant heat cradle, while Astley Cooper ward is provided with a set of apparatus for resuscitation always in readiness for instant use.

One problem remains to be solved: The war has taught us that unquestionably the most effective method of resuscitation is transfusion, and this method we are practically unable to make use of at Guy's because of the difficulty of finding donors. What we require is a number of donors at hand who could be called upon at any moment to give blood. This is the method practised in more than one American Hospital, and we see no reason why such an arrangement should not be possible at Guy's.

WE are not yet fully acquainted with all the results of the Final London M.B., B.S. Examination, but we should like to take this opportunity of heartily congratulating Mr. L. S. Debenham, who has obtained Honours in Medicine and Pathology, and Mr. A. E. Sawday, who has passed with Honours in Surgery.

GUY'S '89 CLUB.

IT is proposed to revive the Annual Meeting and Dinner, which have been in abeyance during the past four years of war, and a "Victory" Celebration will be held either on the last Wednesday in June or on the first Wednesday in July, if possible at the Café Royal, Regent Street. Mr. W. Sampson Handley, President, will occupy the chair, and the Secretary, Dr. H. J. Spon, 61, Harley Street, W. 1, will be glad to hear from all those members wishing to participate, and to have the addresses of those still on service in order to secure a full and representative attendance.

WE believe that a long-felt want will be supplied in the formation of a Medical and Dental Agency at Guy's Hospital. The agency is to be in the hands of Mr. Winston, Wills Librarian, and will be, at any rate to begin with, for Guy's men only. The advantages of such an agency at Guy's are manifold and so obvious that little attention need be drawn to them. It may, for example, help a great deal towards bringing Guy's men together outside the Hospital, both at home and abroad. Again, it will be a great convenience to present Guy's men who may be saved a good deal of trouble in looking for posts upon leaving the Hospital. It is earnestly hoped all Guy's men will co-operate to ensure for the scheme the success it deserves.

THERE will be a Debate under the auspices of the Intercollegiate Debating Society between representatives of the American Forces and the London University on June 5th, at 5.30 p.m. This will be held at University College, and the subject is "That a national minimum wage should be universally adopted." This should prove of exceptional interest, and the prosperity of this Society is now well known at Guy's.

ABOUT a year ago we drew attention in these pages to the great difficulty of obtaining microscopes at that time. The shortage was due to the fact that practically no English firms have manufactured microscopes during the war, while German makes were, for obvious reasons, unobtainable. The scarcity was severely felt at Guy's, because, not only was the Medical School unable to provide instruments for demonstration at Physiology Classes, but students as well were unable to buy them. Accordingly an appeal was made for microscopes to old Guy's men. The appeal met with a very welcome and generous response. Several excellent instruments were presented to the Medical School for demonstration purposes, and many others were sent along for sale to students.

Now the same difficulty has again arisen; it is still very difficult to obtain microscopes, good or bad, while the number of men at Guy's requiring microscopes for everyday use is greater than has been the case for several years. The Physiology Classes are actually held up on account of this difficulty. There must be many old Guy's men who are in a position to confer a very real boon upon their old School. We appeal to any who have microscopes that they can possibly afford to do without to send them to the Medical School, addressed to the Dean, either for sale or as gifts for demonstration purposes. The Medical School will be most grateful to any who will help to tide over a very serious difficulty.

Guy's War Memorial Fund.

	£	s.	d.
Amount acknowledged ...	£3,348	6	8
Roberts, R. J.	2	2	0
"V. F. S."	5	0	0
Stallman, J. F. H.	1	1	0
Luce, P. E.	2	2	0
Ingram, Alex.	5	5	6
The Residents (per A. Alan Forty) ...	52	10	0
Aroni, J.	0	2	6
Pritchard, G. B.	5	5	0
Goodall, E. W....	5	5	0
Kitchin, E. Hugh	5	5	0
Godding, H. C....	2	2	0
Scales, J. E.	1	1	0
Muir-Smith, L.	5	5	0
Turner, F. Douglas	5	5	0
Sturdy, H. Carlile	2	2	0
Mitchell, H. V....	2	2	0
"L.L.B."	0	1	0
Smith, G. Bellingham	50	0	0
Conway-Jones, T. J.	1	1	0
Lansdale, W.	5	5	0
Payne, W. W.	1	1	0
Temple, P. G.	1	1	0
Braithwaite, J. V. C.	1	0	0
Crisp, J.	2	2	0
Carpmael, C. E.	2	2	0
Stohr, F. O.	1	1	0
Robertson, C.	5	5	0
Davis, C. S.	50	0	0
Clarke, Astley V.	2	2	0
Hugh-Jones, Ll.	1	1	0
Marriott, Oswald	3	3	0
	£3,576	6	8

*Also Trotter, H. A., Bond for £50--5% War Loan, 1929–1947.

Pass List.

Royal College of Physicians.

Elected to the Fellowship.—Capt. G. H. Hunt, M.D., B.Ch., M.R.C.P.

Having passed the required examinations, the undermentioned gentleman has been elected to the membership.—J. A, Ryle, M.B., B.S.

University of Cambridge.

SECOND EXAMINATION FOR MEDICAL AND SURGICAL DEGREES.

Easter Term, 1919.

PART II.

PHARMOCOLOGY AND GENERAL PATHOLOGY.

A. C. M. Coxon G. H. Oriel

L.D,S.

FINAL EXAMINATION.

The following candidates have now completed their examinations :—

C. A. D. Bishop	G. H. Howe
S. H. Coplans	C. P. Lake
John Herbert	D. C. van der Spuy
S. M. Kropman	J. W. Greenwall
S. E. Tweeney	J. H. H. Griffin
Geoffrey Deeks	J. J. Jordan
D. R. Gaskill	C. A. Moody

Appointments.

R.A.M.C.

To be Acting Major :—Capt. H. F. Joynt.

T.F.

Capt. (Acting Major) R. Eager relinquishes the acting rank on ceasing to be specially employed.

Capt. (Acting Major) C. F. Searle relinquishes his commission on account of ill-health contracted on Active Service, and is granted the rank of Major.

Capt. G. H. Hunt is restored to the establishment, 2nd Southern General Hospital.-Capt. J. M. Fortescue-Brickdale is restored to the establishment.

A.M.S.

Temp. Col. J. Atkins relinquishes his commission and retains the rank of Colonel.

Change of Address.

D. S. Stanley Brook, from 149, Walworth Road, S.E. 17, to Lister House, Godstone Road, Purley, Surrey.

C. J. Symonds, M.D., M.S., F.R.C.S., The Old Rosary, Redhill, Surrey.

Major M. R. Dobson, Rombold House, Ilkley.

A. A. Forty, 24, Park Square, Leeds.

R. J. Pye-Smith, F.R.C.S., Clyda, Ampthill, Bedfordshire.

O. V. Payne, Lansdowne House, Alton, Hants.

Capt. W. L. Gwyn-Davies, Officers' Mess, Convalescent Hospital, Summersdown Camp, Eastbourne.

Major F. E. Hutchinson, Whitehall Hotel, Guildford Street, W.C. 1.

Surg.-Commdr. Arthur Thomas, R.N., H.M.H.C. 2, "Lower Belle," c/o G.P.O.

Surg. Capt. Robley Browne, R.N., c/o Messrs. Stillwell & Sons, 42, Pall Mall, S.W. 1.

D. P. Seymour Price, 51, Sloane Gardens, S.W. 1.

H. Corry Mann, M.D., B.S., from R.N. Hospital, Malta, to Guy's Hospital, S E. 1.

K. L. Bates, Thorne House, St. Albans, Herts.

Papers by Guy's Men.

Capt. H. L. Attwater, M.Ch., F.R.C.S., R.A.M.C.: A simple method of making Dakin's solution.—*B.M.J.*, May 17th, 1919.

W. C. Swayne and another: Quinine as an abortifacient.—*Lancet*, May 17th, 1919.

Sir Kenneth W. Goadby, K.B.E., D.P.H.: Latent infection of healed wounds.—*Lancet*, May 24th, 1919.

Specialities.

Steam Sterilizers for Hospitals and Institutions.

MESSRS. MANLOVE ALLIOTT & CO., Engineers, Nottingham.

The arrangements for the proper sterilization of bandages, surgical dressings, instruments and vessels used in operating theatres at hospitals form a very important past of its equipment, and it is, therefore, of interest to know that various types of sterilizers, designed to meet all the most modern requirements, are offered by Messrs. Manlove, Alliott & Co., who, after many years' close attention to the subject, have perfected a sterilizer on the latest scientific principles which should claim the attention of all those interested.

Space will not allow us to give any further particulars, but Messrs. Manlove, Alliott & Co. have issued some very interesting brochures on the subject, clearly illustrating all details, which they will be pleased to send on application.

The Treatment of Compound Fractures and Joint Wounds of the Upper Limb.

(Hunterian Lecture delivered at the Royal College of Surgeons).

By E. G. SLESINGER.

(*Continued.*)

Wounds of Joints.

While it is certainly open to argument in many cases of compound fracture whether primary suture following excision is the best treatment, taking into consideration the grave results which may follow an imperfect toilet of the wound, there can be little doubt that where joints are involved the chances of a perfect result which immediate cleansing and closure give very greatly outweigh the risks of the procedure. It is perfectly true that the interior of a joint is very readily infected, but at the same time its anatomy and its definitely limited walls render its cleansing a less uncertain task than is the case where wounds of the general tissues of the limb are concerned; while at the same time a *healthy* joint which is suddenly the subject of an injury and consequent infection has a very considerable capacity for dealing with any remaining sepsis, provided the greater bulk has been removed. If such a case is carefully splinted and carefully watched after operation, the patient is in no degree worse off as a result of an unsuccessful attempt at closure than if drainage had been resorted to at first, while where success follows the operation and early movement can be instituted, results are surprisingly good. It is in these cases in particular that the records of the temperature chart are often extremely misleading. A rise to 102° or 103°, not accompanied by any great elevation of the pulse rate is quite common, and can be disregarded if the other signs and symptoms are satisfactory, and where the case is doing well the temperature will usually settle to within normal limits in the course of two, three, or four days. It is often a great temptation to aspirate such a case, to secure the additional moral support that the laboratory can afford, but such a procedure is usually unnecessary since in cases which are going to suppurate the local signs are usually quite definite, while if the case is doing well more harm than good is done by removing Nature's anti-bacterial, anti-tryptic protective effusion. If aspiration is performed, however, it will be found that the anti-tryptic index of the effusion is often of great help in prognosis.

Shoulder-Joint.

Injuries of the *shoulder-joint*, if uncomplicated by fracture, may usually be dealt with conservatively by washing out the joint and closing the capsule. Many people advocate the injection of such substances as ether, formalin, glycerin, etc., into the joint cavity, but here again no very definite evidence exists that these substances are of any real value provided the mechanical cleansing of the joint has been thorough and complete.

Where a severe fracture of the head of the humerus co-exists with the joint injury, sepsis is so liable to lurk behind in the cancellous tissue of the bone, and future painful adhesions are so likely to follow such an injury of the large articular surface of the head, that more radical treatment is often advisable.

In practically all other joints in both the upper and the lower limb—except the radio-humeral joint—opinion has been gradually hardening against the performance of excision as a primary operation, partly because in most cases of fracture into a joint, an excision, which shall be both an excision of the joint and an excision of the wound, involves too great a sacrifice of bone to ensure subsequent stability, and partly because more recent conservative methods have shown how frequently a good moveable joint will follow their use, even in face of extensive fractures running into the joint itself. In the case of the shoulder-joint, however, the results of excision, on the whole, are extremely good, and at the same time the results of leaving a badly damaged humeral head in position are correspondingly bad, both as to function and more particularly as to pain. Where excision *is* decided on and performed, a straight Thomas' splint without a swivel-ring, and with the arm abducted at right angles to the body, is probably the best splint for transport, while where the patient can be kept, the system of slings which will be mentioned later is quite satisfactory and allows of early movement (cf. Fig. 7).

Elbow-Joint.

Open injuries to this joint are not common without concomitant fractures of the bones en-

tering into its formation, but where they do occur they should be treated by thorough cleansing of the joint followed by suture. It is often not possible to reach the joint cavity satisfactorily through the original traumatic opening, and if such is the case, the original track having been excised, the joint may be opened by a longitudinal excision over the head of the radius with the fore-arm prone, through which very satisfactory lavage can be carried out. A further advantage of this method of approach is that it exposes the radio-ulnar joint, or can do, and damage to this important joint can be inspected and dealt with. Unless the original injury has destroyed the greater part of the articular surfaces of the elbow-joint, it would seem best to limit interference as far as possible.

A set excision at this stage has practically nothing to recommend it, since if it is performed it usually necessitates the removal of more bone than is desirable, with the consequent grave risk of a flail joint, while, on the other hand, with the methods now available, even should sepsis follow a conservative operation, the elbow-joint has not, as a rule, proved difficult to sterilise. Every possible use should be made of the tendinous expansion of the triceps to reconstitute a shattered olecranon, and the continuity or otherwise of the ulnar nerve must be verified and dealt with. Where the injury to the articular surfaces renders it useless to hope for a moveable joint, great care must be taken in putting up these cases. The forearm should always be supinated, and the angle at which the elbow is kept must depend largely on the patient's usual occupation and the position in which his arm is likely to be of most use to him. It is quite remarkable, however, how grave an injury is compatible with a subsequently moveable joint, provided severe infection does not occur and active movement is begun early and vigorously maintained. In some cases where the olecranon is already separated and considerable articular damage exists, it is possible to separate the injured surfaces with a flap of fat and fascia and so secure a moveable joint by means of a modified arthroplasty, particularly with injuries in the region of the capitellum. It would seem undoubtedly best where the head of the radius is badly damaged to excise it completely, and in all these cases the limb should be invariably kept in full supination, and movements of pronation and supination begun as early as possible.

WRIST-JOINT.

Wounds of this joint are unfortunately usually accompanied by more or less injury to the neighbouring carpal bones, and the complexity of the synovial cavities in this region renders thorough cleansing of the joint extremely difficult. Where the carpal injury is not too severe conservative surgery is sometimes possible, and fortunately the intercommunications of the synovial spaces are very readily shut off under the influence of injury or infection, so that if early vent is given to any remaining sepsis it is usually fairly easy to keep the process under control. Limited excisions of the carpal bones in response to the nature of the damage present give usually quite good results, provided attention is given to the position in which the wrist is kept afterwards. Dorsi-flexion must be maintained, and the too prevalent ulnar deviation prevented, while at the same time early and vigorous finger movement must be insisted on to prevent tendon adhesions.

Where a thorough excision is not possible and particularly when many of the tendons are divided, it is usually wiser not to aim at primary closure of the wound. In such cases a careful anatomical reconstruction of the divided structures, and as complete as possible a removal of dead tissue followed by the application of such a tissue solvent as Dakin's fluid, will usually allow of early secondary closure, and will spare the patient the dangers of a septic spread which attend unsuccessful attempts at primary suture in this region. If such a case has to be left open, every effort should be made to avoid leaving a tendon or tendons running uncovered through the wound, as these will certainly die. When they cannot be incorporated in the walls of the wound, it is usually better to realise at once their inevitable death, and to make as good a provision as is possible for the resumption of the function they subtend by such grafting or cross-unions as are necessary.

METACARPO-PHALANGEAL AND PHALANGEAL JOINTS.

Injuries to these joints should be treated as conservatively as possible, and every attempt should be made to secure primary union, since if infection is once allowed to occur, the intimate association of the tendons with these joints renders their secondary sterilisation a long and tedious process. In dealing with the phalangeal joints the dorsal tendon sheath should be reconstructed or united as accurately as possible,

since otherwise the very painful condition of "snapping finger" is likely to result. Sinclair's ball splint is, perhaps, the best in the after-treatment of these cases, and the Gooch splinting attachment permits of graduated and increasing movements.

Perhaps the most difficult problem for the surgeon in the early treatment of all these severe injuries is the decision as to when excision and suture should *not* be performed. He must be guided partly by the length of time since the infliction of the injury, partly by the anatomical possibilities of the wound, and partly by the nature of the infection present, if known. Gas bacillus infection is not greatly to be feared where the main vessels are intact, since a wide excision of all dead or damaged tissues will usually prevent its development, and further, its presence is readily recognised by the indications present in the wound, and by the character of the pulse and the "temperament" of the patient. The most dangerous infection possible in these cases is that caused by the hæmolytic streptococcus, and the outlook in this condition is always extremely grave. Whatever the exact biological nature of this Bolshevist organism may be, it spreads with amazing rapidity, and nothing but the earliest and most extensive surgical procedure seems at all able to cope with its extension, and even with the most radical surgery the chances of success are usually extremely slender.

INFECTED WOUNDS,

Having now very briefly reviewed some of the principles which underlie the early treatment of these severe injuries to the upper limb, it remains to consider the methods to be adopted either when the case is seen too late for primary excision and suture to have a chance of success, or when this method has been tried, but has failed owing to the subsequent development of infection. This second line of treatment represents mainly the work as performed in the base hospitals in France, and as has been before pointed out was separated from the first line by an interval occupied in transport. Consequently where we attempt to apply the lessons of the war to civil surgery it will usually be advisable to adopt in conjunction with "first line" surgery the splinting of the "second line," since these splints are very much more satisfactory from the point of view of successful treatment, but owing to their inconvenience in transport, were inapplicable to first line work under war conditions in the field.

In discussing this second line of treatment, two sides of the subject have to be considered, namely (1) the treatment of the wound itself, (2) the treatment of the part wounded; but it must be remembered that each is the necessary corollary of the other. It is chiefly in the field of pure wound treatment during this infected stage that the great controversy of opinion and practice has been waged during the war, and it is here that the reactionaries of the antiseptic school and the progressives of the physiological school have fought their greatest battle. At first sight it seems natural enough to hope that since sepsis is caused by organisms, the introduction of some antiseptic body will destroy the organisms and so render the wound clean, and the promises of the laboratory, their "therapeutic co-efficients" and their "bacteriological efficiency" are so brilliant in theory that if they fail in practice the tendency is to blame the detail of technique when in reality the underlying principle is wrong. There can be little doubt, however, that the treatment which is most likely to provide practical success is that which most closely imitates Nature's own treatment or which exaggerates it to meet the aggravated conditions present, and it is in the interpretation of these processes that the experimental work of Sir Almroth Wright and his co-workers has been so valuable. Approximately it may be said that when dealing with an infected wound the natural reaction of the body is to limit as rapidly as possible the depredations of the invading organisms by destroying the food on which they live, and at the same time to guard against their further invasion by setting up a strong zone of defence around the wound. The first purpose is accomplished by the liberation in the wound, from dead pus cells, of trypsin which splits up the protein of the dead tissues and deprives the organisms of their necessary pabulum. The second is secured by the speedy construction of a band of leucocytic infiltration and, as a guard against the activity of the body's own agents, by an increase in the normal antitryptic activity of the serum.

It is thus seen that both in the pre-infected and in the infected stages of a wound, the same general principles underlie its treatment, namely, the thorough removal of all dead or dying tissues, and that the sole difference consists in the fact that before bacterial spread

has occurred the process can be carried out quickly by means of the knife, while at a later stage, where the line between living and dying tissues is no longer distinct, the slower process of hydrolysis must be resorted to.

We have here, then, a natural line of wound treatment along which success is to be expected, and if it be granted that such a natural method *is* the most likely to lead to success, it is difficult to find on what basis of principle the antiseptic school rest their hopes in the treatment of *actually septic* wounds other than the doubtful ones of custom, and a supposed analogy from fundamentally different laboratory experiments.

In the neutral hypochlorite solution of Dakin and Daufresne we have a substance of very great proteolytic value, and one which, in addition, destroys itself in the process, a fact which prevents its interference in any way with the normal action of either leucocytes or tissue cells. Its action on protein in solution is almost instantaneous, while on coagulated protein its action is many times more rapid than that of trypsin. Experiments on the action of a 0·5 per cent. hypochlorite solution on coagulated albumen, gelatin, albumen in solution, and dead tissue, showed that coloids were dissolved and dissolved protein hydrolysed, the various stages of the formation of alkali albumen, proteoses, peptones and lower products being readily followed. The rapidity of the action is well seen by two experiments. In the first, if a solution containing 5 per cent. egg-white and 0·5 per cent. hypochlorite is incubated for eight hours at body temperature, no protein, proteose or peptones can be detected, although all these substances are readily demonstrated during the course of the experiment. In the second, an artificial wound was constructed by placing a weighed piece of meat on a tray in a Petri's dish under sterile conditions, the whole being kept at body temperature. In one case two-hourly irrigation with two ounces of Dakin's solution was carried out and in another a similar procedure with normal saline. In each case a piece of meat weighing 1½oz. was used, and the one irrigated with Dakin's solution was completely dissolved in 72 hours while the one where saline was used was almost unaffected.

This all-important action of the hypochlorite solution is, of course, a purely chemical bulk action, and the amount to be used must be proportionate to the tissue to be dissolved, a fact which accounts for the apparent failure of hypochlorite solution in Sir Almroth Wright's "artificial slough" experiment.

It would seem probable that along this line —the hydrolysis of dead tissues and the consequent secondary sterilization of the wound— lies the most probable avenue for advance in the treatment of infections. A great deal of work remains to be done and whether further research shows ferment action or some form of chemical or bacterial hydrolysis to be the most successful, sufficient is already evident to establish the principle that the speediest way of dealing with an infection is to remove those substances in the medium which are essential for bacterial growth, rather than to attempt to remove the bacteria from the medium.

In the treatment of infected wounds, therefore, as regards the wound itself, Nature's tryptic digestion has been replaced by hypochlorite hydrolysis, the hypochlorite being introduced into the wound in the form of intermittent irrigation with Carrel's tubes. Dakin's fluid so employed is used solely for its hydrolytic power, and it is a coincidence, and perhaps an unfortunate one, that in a test tube this fluid possessed a high, so-called "bactericidal" power.

The fact that a few seconds after its introduction into an actual septic wound suffices to destroy the hypochlorite as such, and the additional fact that organisms can be found growing on any isolated portions of dead tissue remaining in a wound which has been bathed in the solution, should be sufficient to vindicate it from any charge of antiseptic action in vivo, and prove, if proof is required, that its hydrolytic power is responsible for its undoubted success.

Nature's second method of dealing with an infected wound—namely, the establishment of a zone of leucocytic defence round the wound —is best aided by the maintenance of absolute rest and as perfect an alignment of parts as is possible, and further, by a minimum of operative interference on the part of the surgeon while infection is active.

Treatment of the Part Wounded.

When splinting an injury of the upper limb at this stage, it is possible to have regard solely to the purposes which the splint is intended to secure, and the question of transport need no longer limit the choice. In weighing the question of what type of splint should be

adopted, several factors have to be considered, and it is proposed to mention, firstly, the objects which it is desired to achieve before discussing the manner in which an attempt has been made to secure them.

In the stage of treatment which we are considering, namely, roughly the first month of the existence of the injury, the patient will usually be kept in bed and consequently splinting must be so arranged that while the rest and position of the limb involved is maintained, at the same time full mobility is secured for the rest of the patient's body, and he must be able to move freely in bed without risk of further injuring himself.

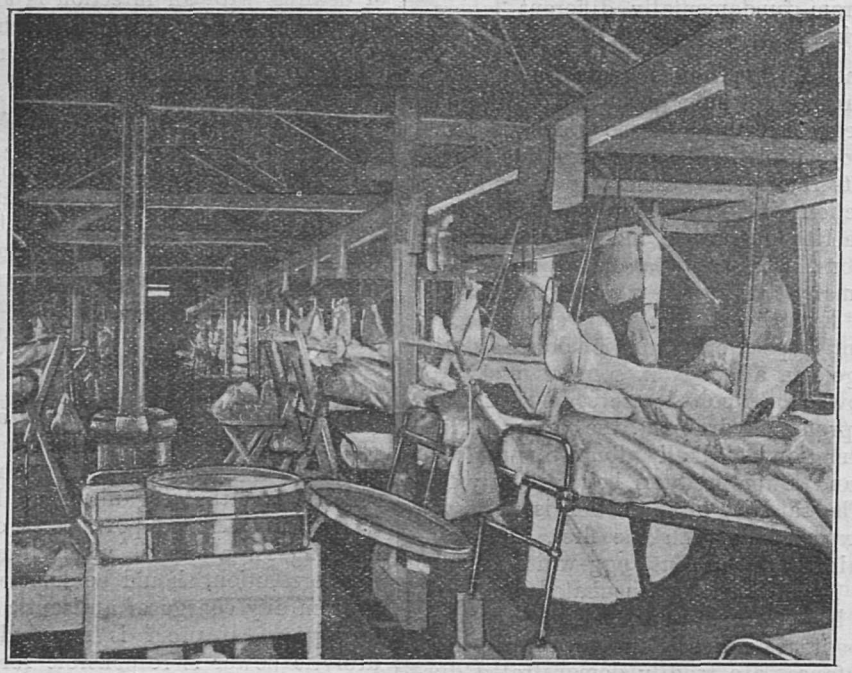

FIG. 1.—Ward fitted with superstructure carrying universal crossbars for suspending splints. This superstructure can be fitted to any ward.

To meet this requirement the counterbalanced suspension method was used and the fracture wards were fitted with a permanent superstructure carrying adjustable cross bars from which any splint can be suspended in counterbalance by means of cord, pulleys, and sand-bags (see Fig. 1). If the arm is extended by a running weight the same position relative to the body is constantly maintained and no movement of the patient can disturb the relative as opposed to the absolute position of the limb in its splint. In deciding in what position the limb should be placed, two factors must be borne in mind: firstly, the fractured bones must be brought into and maintained in as perfect a position as possible, and secondly the musculature of the limb must be held in the position which will best favour its subsequent resumption of functional activity. Now the mechanics of the upper limb are rather altered by the fact that the human body is usually active in an upright position. Roughly, we have a series of bony levers acted upon by forces represented by different groups of muscles and moving weights dependent upon the act which is being performed. With the body erect, however, certain groups of muscles have, in addition to the act which they are helping to perform, to overcome the weight due to gravity, and they are thus permanently at a disadvantage when compared with their opposing groups.

Consequently, when the whole limb has to be put into what may be termed the optimum repair position, this fact must be borne in mind, and it must be realised that when func-

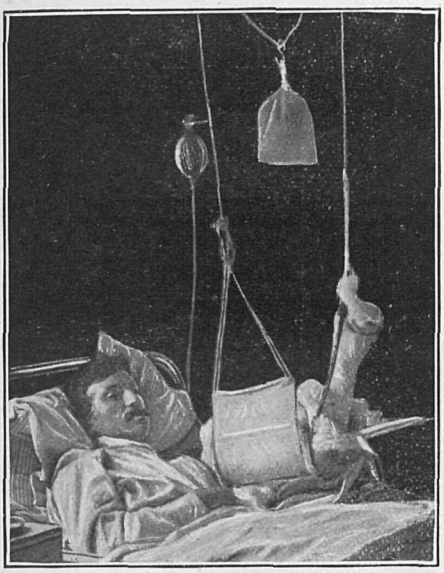

FIG. 3.—"Suspension-extension splint" for compound fracture of humerus.

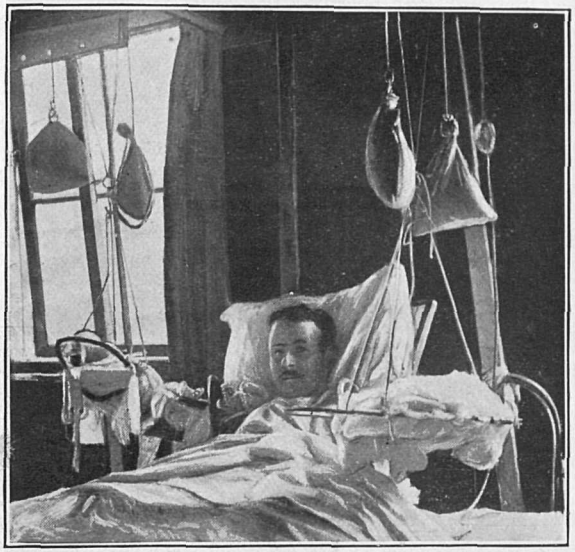

FIG. 4.—Double compound humerus fracture, counter-balanced in bent-arm Thomas's splint.

FIG. 5.—Suspension extension tray for severely lacerated fractures of forearm in first stage of treatment.

Illustrating Mr. E. G. Slesinger's Hunterian Lecture on "The Treatment of Compound Fractures and Joint Wounds of the Upper Limb."

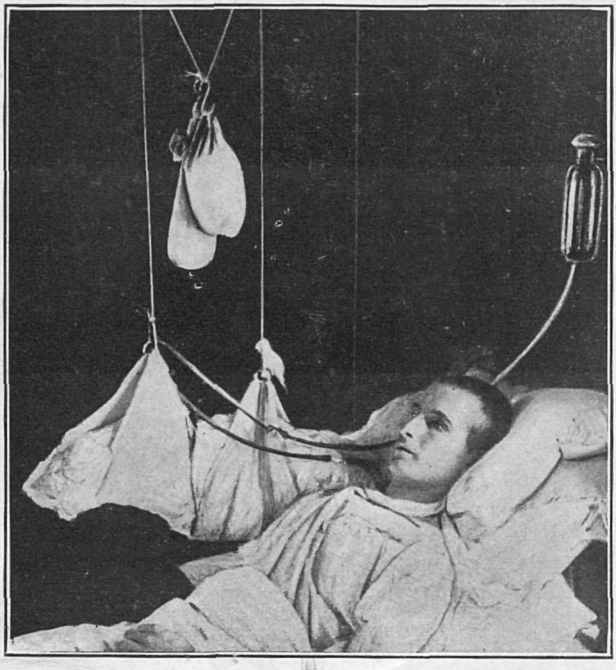

FIG. 7.—Suspension slings for shoulder-joint wounds and compound fractures of the scapula.

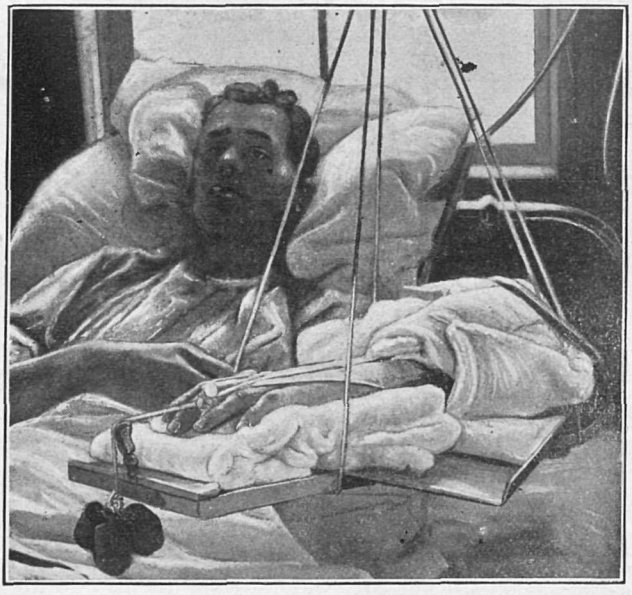

FIG. 8.—Wound of elbow-joint on "suspension-extention tray."
(Note.—The side attachment to secure supination is not in place in this illustration.)

tion is resumed the gravity-aided muscles will start with an advantage over their opponents which the latter will not be able to cope with unless provision has been made to deal with it beforehand. There seems little doubt that this gravity effect is largely responsible for the so-called preponderance of certain groups of muscles, and its results are well seen in cases of infantile paralysis, where, after a complete paralysis of the limb, recovery is much more common in the gravity-aided muscle groups.

The shoulder is abducted and flexed at right angles to the body, the arm is externally rotated, the forearm is flexed at right angles, and is kept in extreme supination while the wrist joint is extended, and the fingers are held abducted and extended. This position has been used in dealing with the majority of fractures of the humerus and of the bones of the forearm, excepting only in cases where its adoption is unfavourable to the maintenance of correct bony alignment. The method employed

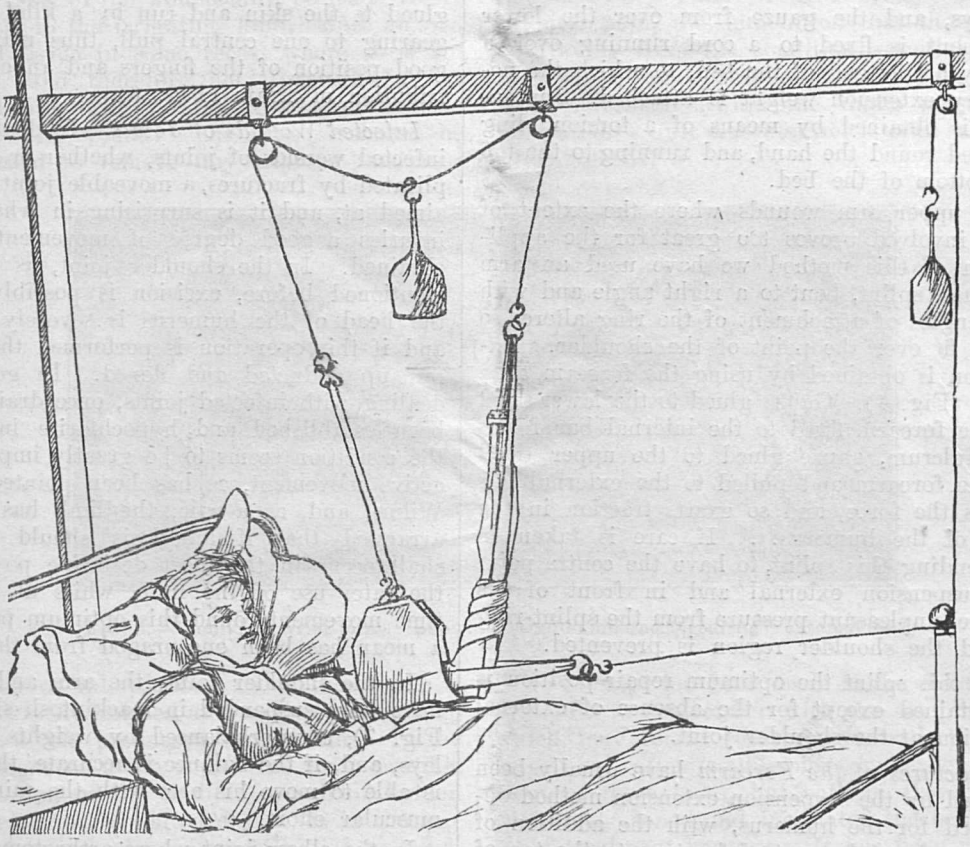

FIG. 2.—Method of applying suspension extension splint to fracture of humerus.

Consequently, when putting the upper limb into its optimum repair position, the gravity-opposing muscles should be as far as possible kept shortened, as under these circumstances they will maintain their tone. Their gravity-aided opponents will be readily helped by Nature to regain their function when activity is resumed. The position which best fulfils these conditions, and is at the same time convenient for wound treatment, is as follows :—

is what has been called the suspension extension splint, and is applied as follows (Figs. 2 and 3) :—

For example, in the case of a fracture of the shaft of the humerus, Sinclair's glue is applied to the front and back of the forearm and gauze strips are fixed to it, while at the same time a glove is glued to the hand, leaving the thumb and fingers free. Further, gauze strips are glued to as great a surface

of skin over the lower fragment as is possible. A mackintosh sling is applied over the dressings round the fracture and is suspended by a cord which, running over two pulleys in the superstructure, has its other end attached to a hook. To this hook are fixed, firstly, the gauze strips from the forearm, also the strings which emerge from each glove finger, so that the forearm can be suspended either by the hand, glove, or the forearm strips, or both, at will. The necessary weight to secure an accurate counterbalance is fixed to the cord between the pulleys, and the gauze from over the lower fragment is fixed to a cord running over a pulley at the end of the bed, to which the necessary extension weight is attached. Supination is obtained by means of a torsion sling applied round the hand, and running to the top or bottom of the bed.

In upper arm wounds where the extent of skin involved proves too great for the application of this method we have used an arm Thomas' splint, bent to a right angle and with the angles of attachment of the ring altered so as to fit over the point of the shoulder. Extension is obtained by using the forearm as a lever (Fig. 4). Gauze glued to the lower third of the forearm fixed to the internal bar forms the fulcrum, gauze glued to the upper third of the forearm and pulled to the external bar forms the force, and so exerts traction in the line of the humerus. If care is taken in suspending this splint, to have the centre point of suspension external and in front of its centre, unpleasant pressure from the splint-ring round the shoulder region is prevented.

In this splint the optimum repair position is maintained except for the absence of external rotation at the shoulder joint.

Fractures of the Forearm have usually been treated by the suspension extension method described for the humerus, wtih the addition of a sling from the seat of fracture to the top of the bed, which counteracts any tendency of the fracture to sag. Where the wounds are very extensive or very septic they have usually been first treated for a time on a form of suspension extension tray. This consists of a metal tray from which a drainage pipe runs, and which has a wooden upright against which the upper arm rests to serve as a counter extension. The wooden attachment runs forward under the tray and has at its end a pulley over which runs a cord, taking extension, either from the lower forearm or the fingers, according to the situation of the wound (Fig. 5). In fractures of both bones a wooden side-piece with straps is added so that the forearm can be treated in supination. The whole apparatus is counterbalanced in suspension; the drainage tube is connected to a bottle at the side of the bed, thus avoiding any wetting from the solution introduced into the wound. In wounds of the carpus and lower third of the forearm this splint has also been used, usually with a wedge attachment to secure adequate dorsi-flexion of the wrist. Extension is obtained by glove fingers glued to the skin and run by a kind of wood gearing to one central pull, thus maintaining good position of the fingers and an equal distribution of strain (Fig. 6).

Infected Wounds of Joints.—In dealing with infected wounds of joints, whether or not complicated by fractures, a moveable joint has been aimed at, and it is surprising in what severe injuries a good degree of movement can be obtained. In the shoulder joint, as has been mentioned before, excision is possibly best if the head of the humerus is severely injured, and if this operation is performed the arm is put up abducted and flexed. In general in dealing with infected joints, once drainage has been established and hypochlorite introduced, the condition seems to be greatly improved by active movement, as has been pointed out by Wilms, and, as a rule, the limb has been so arranged that if ankylosis should occur, it shall occur in the most desirable position for the later use of the limb, while at the same time movement round this optimum position as a mean has been encouraged from the first.

In the shoulder joint, the arm and forearm have been suspended in mackintosh slings (see Fig. 7), counterbalanced by weights and pulleys, and, if the balance is accurate, the patient is able to move his arm with the minimum of muscular effort.

In the elbow joint where arthrotomy has had to be performed, the vertical incision over the head of the radius has been used, which by a downward and inward extension will also serve to expose the radio-ulnar joint. These cases have been treated on a modification of the suspension extension tray, the tray being so slung that its position of rest is that in which ankylosis, if it should follow, is desired to occur (Fig. 8). If this splint is carefully counterbalanced, all the movements of the elbow can be carried out, without in any way interfering with the treatment of the wound.

In regard to the wrist joint, cases of infection of this joint have been treated in dorsiflexion and have been kept strictly immobilised, since the advantages of early movement do not compensate for the risks of spread of the infection along the tendon sheaths and the communicating synovial spaces in this area. In the metacarpo-phalangeal regions the same methods have been used as described in the early first line treatment.

As to the surgical treatment of these infected wounds, the essential condition is that all pockets and portions of the wound must be made freely accessible to the irrigating fluid, since an area of dead tissue in some recess where it is not reached, and therefore not dissolved by the hypochlorite, will, at the least, continuously re-infect the wound. The scissors should be freely used to remove any exposed tendinous expansion or intersections, as tendon tissue is very slowly hydrolysed and is very apt to keep up a slow and prolonged suppuration. In the early stages of acute sepsis the least possible manipulation of the limb in search of hidden or pocketed pus would seem best, as in the majority of cases, where immobilisation is good, a barrier will be created against any general spread of infection, and pus, if it is formed, will be local in site, and readily dealt with when the moment arrives.

Some form of bacteriological control should be instituted in these cases, and when what has been termed "surgical sterility" is reached, secondary suture can be carried out, with a large percentage of successful unions. All through the treatment of these cases attention to the wound must be parallelled by care that the restoration of function is encouraged by every possible means, and of such means early active movements are much the most important. Fortunately there is a satisfactory guide to the extent to which movement can be carried out, in the pain which follows any excessive motion. If the limb has been arranged so that movement does not disturb its correct alignment, active movement can safely be encouraged in all cases within the limits to which pain forms a safe and certain guide.

As Hilton pointed out, "every deviation from the necessary state of rest brings with it, through pain, the admonition that the patient is straying from the condition essential to his restoration," and conversely where pain is absent, movement within the limits possible to the patient's own musculature, is both safe and advantageous.

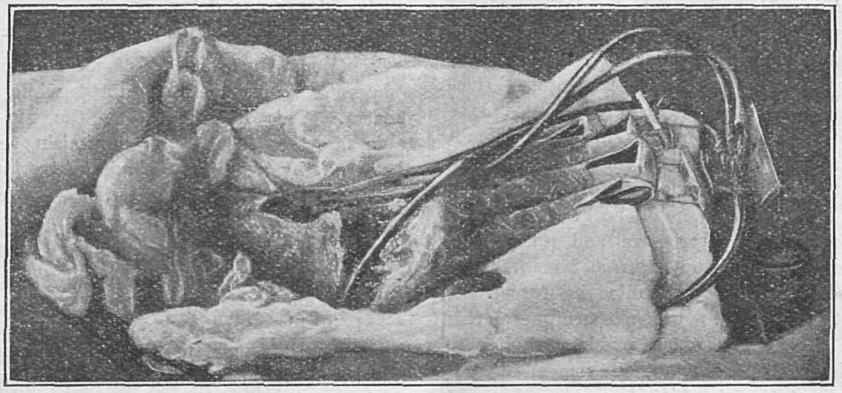

FIG. 6.—Wound of wrist-joint. Showing dorsiflexion and "gearing" extension.

No attempt has been made in the short space available to deal either with the complications which may retard recovery, or with the prolonged and often troublesome convalescent treatment of these cases, but both of these stages will be shortened and facilitated the better the early treatment becomes. It has been my endeavour merely to indicate one of the several paths along which Nature, the most successful surgeon of all, points the way, and I have ventured to maintain that it is at any rate a logical one.

I would like to express my great indebtedness to my colleagues, Captains Chapple, Saner, and Morgan, for the readiness with which they have allowed me to use work which was largely jointly carried out.

The Application of War Surgery to Civil Practice.

BY A. D. MARSHALL.

Paper read before the Pupils' Physical Society on May 1st, 1919.

Mr. President and Gentlemen,—With your permission I will confine my remarks to discussion of the treatment of patients suffering from Shock and allied conditions. Experience has taught us valuable lessons, and all who worked in clearing stations must have been struck by the steady improvement in the results obtained during the last three years of the war. Let us consider how this experience would apply to the treatment of badly injured patients brought to a civil hospital. Most of these require surgical interference, so we will divide treatment into three periods:—(1) Before; (2) During; and (3) After operation.

Before operation.—It took much tragic experience to teach the importance of thorough deliberate "resuscitation" before operation. *Do not rush your patient to the operating theatre.* Where internal hæmorrhage is suspected it is unwise to delay operation, but in other cases the best results will be obtained if the patient be given two or more hours in which to benefit by your treatment before being taken to the theatre; his condition should be gauged by frequent observations of blood-pressure and pulse-rate.

The first necessity is to stop external hæmorrhage; if bleeding vessels cannot be controlled by forceps or sutures, do not hesitate to use a tourniquet; this may be left on for hours without much prejudice to the patient's chances of recovery. I remember seeing at a clearing station in 1915 two cases brought in together; each had both legs shattered below the knee, and each had had two tourniquets applied. One patient had a fair pulse and was operated on shortly after admission; he died three hours later. The second patient was pulseless for some hours, the tourniquets were not removed, and he was kept in a warm bed for twelve hours. He was then subjected to a similar operation under the same anæsthetic as the first patient and he recovered.

The main principles of treatment are warmth, rest and fluids. The patient should be put into a comfortable bed as soon as possible after admission. It is better not to change his clothing unless this is wet. Warmth is obtained by means of an electric cradle or hot vapour bath; rest, by the relief of pain (splints, small dose of morphia); fluids should be given by the most natural route available. The best results are obtained when they are given by mouth, judging not only by clinical experience, but also by observations on blood-concentration and blood-volume made by myself and Captain O. H. Robertson. The next best method is rectal infusion; subcutaneous salines seem to be of no benefit to a patient with a very low blood-pressure, as the fluid remains unabsorbed for many hours. Judging by my blood-pressure records, intravenous injections of saline did more ultimate harm than good. With regard to gum saline solutions, opinion is still divided. I have not seen any harm resulting from them, but, on the other hand, never obtained the strikingly good results reported by some observers. If the patient's condition is grave, and does not respond to any of these measures, and if, on examination of his blood, it is found that the hæmoglobin is dilute, say 85 per cent. or under, then you are bound to give a blood transfusion. This is preferably performed by means of a modified Kimpton Tube, 6,000 to 10,000 c.c. of whole blood being injected. If this apparatus is not available, the citrate method may be employed, its only disadvantage being that the improvement in the patient's condition will not be so rapid. Blood from donor and recipient should be examined for compatibility, but it is worthy of note that accidents from mixing untested bloods are rare, so that in a desperate case it is not worth while to make a preliminary test if it will involve dangerous delay.

We now come to the second period—

Treatment during Operation.—The patient's body temperature must be maintained while he is in the theatre. This is ensured by the use of a heated table, a warm theatre, by minimising exposure, and, above all, by avoiding the administration of icy cold anæsthetics such as open ether. If ether be employed it should be given as a warm vapour by the Shipway apparatus. The choice of anæsthetic is of the greatest importance in dealing with patients suffering from shock or hæmorrhage. George Crile stated in his report from France that the bulk of the preventible mortality at clearing stations was due to "wrongful anæsthesia." This was fully borne out by our experience, for when gas-oxygen anæsthesia was substituted for ether and chloroform in severe operations, such as amputations through the thigh, there was a striking improvement in the recovery rate. With this anæsthetic it was found possible to operate successfully on abdominal cases which before had to be left as hopeless. In operations on the abdomen the surgeon can do much to minimise the shock of operation. The first principle is to keep all gut as far as possible within the abdominal cavity. Exposure of more than one coil of gut outside the abdominal cavity leads to a rapid and continuous fall of blood-pressure; gentleness is also of importance; so also is the position of the patient. I have seen several bad cases killed by being rolled on to one side towards the end of a long operation. For some reason this procedure always leads to a great fall of blood-pressure. In abdominal cases muscular relaxation should be produced, not by the general anæsthetic, but by local infiltration of the skin, muscle and extra-peritoneal tissue with a solution of novocain and potassium sulphate before incision.

We now come to the third period—

Treatment after Operation.—Here the same measures may be employed as in the first period, *i.e.*, warmth, rest and fluids. It is one of the great advantages of gas-oxygen anæsthesia that vomiting seldom follows and that fluids can be given by mouth a few minutes after the end of operation.

It has been the fashion to give hypodermic injections of strychnin, pituitrin, or camphor to patients in bad condition after operation. As judged by their effect on the patient's blood-pressure, I believe these injections do much more harm than good. Crile points out that their effect is very similar to that of a thumb-screw, so if we feel bound to do something to these cases, let us apply a thumb-screw, it will be more economical.

The cases we have been considering are those of severe injuries; similar measures should probably be adopted in dealing with other grave surgical conditions.

Mr. Mullally expressed his full concurrence with all that Mr. Marshall had said. He suggested that the best place in which to attempt resuscitation would be in the Accident Wards. The necessary quiet would be obtained by using a bed isolated by screens in the far end of the ward. Warmth could best be applied by a radiant heat cradle covering the patient and producing a temperature of 110°—120°F. This could be worked from the wall plugs already present. It should be a simple matter to provide the necessary instruments, etc., for transfusion of blood or other fluids in a convenient and readily accessible form in the ward itself.

He then dealt with the use of morphia in badly-shocked patients. It should be given with great care and discrimination, especially in the early stages of shock. Frequently an initial dose failed to produce the effect expected, and there was a tendency to repeat the dose. This might easily prove fatal, since, when improvement in the general condition set in, the morphia began to take effect and quickly produced a condition of morphia-poisoning in which the patient lay in a condition of semi-coma, slightly cyanosed and breathing very shallowly. Such patients failed to react to further resuscitation and were very difficult and dangerous subjects for anæsthesia. Morphia should, if possible, be withheld until definite signs of recovery had appeared. If extreme pain and restlessness made its use imperative, an immediate effect must not be expected.

Dealing with the treatment of recent lacerated wounds, Mr. Mullally pointed out that the ideal to be aimed at was the conversion of the soiled area into a "surgically clean" wound. This could be achieved most rapidly and most efficiently by careful excision of the whole of the soiled area. An attempt should be made to excise the whole area in one mass, and if this was impossible the greatest care must be taken to avoid any contamination by soiled instruments or fragments of tissue of the fresh wound surface. If the excision had been successful, the whole wound should be sewn up in layers at once. If any doubt existed it should be packed with gauze, then if, on the fourth day, it was still clean suture could be done; if, on the other hand, the wound was septic it should be treated by the Carrel-Dakin or other suitable method and sutured secondarily when sterilisation was effected.

In conclusion the speaker put in a strong plea for the use of the Thomas' knee splint for the fixation of fractures of the femur and leg during transport from the surgery to bed and from bed to the X-ray room. The splint saved the patient much unnecessary suffering and made him more easy to transport and to examine. The long Liston splint was strongly condemned on the ground that it did not fix the injured limb, did not save the patient from pain, and did not appreciably facilitate transport. If possible the Thomas' splint should be put on in the Surgery and kept on until examination was complete and the final treatment about to be carried out.

Mr. Slesinger agreed with the points brought forward by the previous speakers. While it is no doubt true that the number of cases of severe accidents comparable with the casualties of warfare is small, yet in the number of cases admitted for results of some abdominal catastrophe a large field exists for the application of resuscitation methods. These should begin at once, and the provision of adequate heating arrangements, *e.g.*, electric light cradles or electric torches, in the surgery was advocated. By this means the necessary delay before admission becomes advantageous to the patient. The war experience that resuscitation before operation improves the prognosis would probably apply to many cases in civil surgery, though the safe limit of delay is often difficult to decide.

The experiences of the war in regard to head injuries has proved full of suggestion. Local anæsthesia in all cases gave better results than general anæsthetics, including gas and oxygen. Operation need not be immediate if the pulse rate is not rising, and when operation is performed everything depended upon the possibility of closing the dura.. "Postage stamp" fascial grafts had proved the best way of dealing with wounds of the sinuses, and lumbar puncture was important in after-treatment.

The surgery of infected wounds offers the greatest field for adaptation to civil work. The great importance of preventing secondary infection is receiving increasing attention. This is well shown in cases of empyema, where the method of Captain C. Dean of surrounding the drainage tube with a Carrel tube by means of which the dressings are kept moist with Dakin's fluid has greatly improved results. In every

infected cavity the ideal to be sought is the sterilisation of the cavity and its ultimate closure by secondary suture. In soft part wounds this is readily accomplished by the Carrel method. Its advantages are very great, particularly in the avoidance of adhesions, hernias, etc., and it offers a large field for work. The abdomen is readily dealt with by Dakin's fluid when localisation of infections has once been established.

This war has tended to reverse the treatment of suppurating joints. Tubes and immobilisation have been replaced by drainage without tubes and irrigation, and the work of Willems has shown that patients with well-drained infected knee-joints can walk on them with benefit to themselves and their joints. Carrel treatment down to the capsule can be combined with this method. Syringing of wounds has been almost universally abandoned, and the employment of a uniform method of dressing septic wounds leads to great saving of time and expense. The suspension method of treating fractures has become more wide-spread since the war, though it is no new thing. Its chief advantages are added comfort and relief from pain to the patient, greater accessibility to the surgeon, less work for the nurses, and better alignment, and more readily instituted movement for the injured limb. The Thomas' splint, used on the principle of the Hodgen splint is simple and efficient, and can easily be converted into a calliper when walking is permitted.

Mr. Ryle stated that, although he had not done any war surgery himself, he had had the advantage of co-operating with war surgeons in the resuscitation, reception and chart wards of a C.C.S. In his opinion one of the most important surgical lessons of the war was the practical demonstration it gave of the value of organised co-operation—or "team work." In the treatment of chest wounds, for instance, the collaboration of physician, surgeon, bacteriologist, radiographer, and anæsthetist had produced the most encouraging results. The work of the bacteriologist in particular in the investigation of wounds and general infections had explained the reason of the good and bad results in surgery and paved the way for new advance in technique. A similar co-operation should become the rule in civil work, and it should, as far as possible, be made a close and systematic co-operation rather than a loose co-ordination of departments.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Hospital Dental Society.

The Twentieth Annual Dinner.

After an interval of five years, a record gathering assembled in the grand hall of the Connaught Rooms, Great Queen Street, E.C., on Saturday, May 10th, for the Twentieth Annual Dinner of the Guy's Hospital Dental Society. This very successful function constituted both a happy re-union of past students of Guy's and a cordial manifestation of the popularity of the President of the Society (Mr. Montague F. Hopson), who occupied the chair.

Among those present were:—Mr. H. Cosmo Bonsor (President of Guy's Hospital), Sir Alfred Fripp, Mr. L. Bromley (Dean), Dr. Fawcett (Senior Physician), Mr. C. F. Rilot (President of the British Dental Association), Professor Wright, Mr. Norman G. Bennett, Mr. W. H. Dolamore, Mr. S. Spokes, Colonel E. B. Dowsett, D.S.O., Lieutenant-Colonel J. P. Helliwell, Major H. D. Gillies, Captain W. Kelsey Fry, M.C., Messrs. E. H. Pelham, L. Matheson, R. Wynne Rouw, J. L. Payne, F. J. Pearce, G. Northcroft, T. B. Layton, W. Rushton, T. A. Coysh, H. C. Malleson, C. A. Clark, F. N. Doubleday, C. E. Wallis, F. Bocquet Bull (Hon. Secretary of the Dinner Committee), J. Rhys Herbert (Hon. Secretary of the Dental Society), and S. H. Coplans (Hon. Treasurer).

After the loyal toasts, the Chairman proposed the toast, "In Memoriam." He said five years had elapsed since they had gathered round that board and in the interval there had been happenings such as the world had never before witnessed, but under Providence they had come through. They had lived to see the realisation of the hopes expressed by the immortal John Keats in lines written in the very year in which he entered Guy's as a student—

"In the long vista of the years to roll,
Let me not see our country's honour fade;
O let me see our land retain her soul,
Her pride, her freedom—and not freedom's shade!"

Continuing, Mr. Hopson said he held in his hand a list headed "Pro Patria," which he dare not trust himself to read. It contained the names of 111 Guy's men, who went forth in search of a great ideal and found it. He asked them to stand in humble reverence for the undying dead, whose memory "liveth for evermore."

The company stood in silence while the orchestra played Chopin's Marche Funèbre.

Mr. Rilot proposed the toast of "Guy's Hospital and Schools." He said they had every reason to be proud of their hospital, which he recently had the

privilege of visiting under the guidance of Mr. Hopson. He went through many of the wards, inspected the Medical School with its beautiful library and splendid museum, and visited the Dental School, which was not the least important part of that great institution. It was becoming increasingly recognised that the true aim of medicine was prevention rather than cure, and he claimed that dentistry stood in the forefront of preventive medicine, as one could not have a healthy body without a healthy mouth. This Dental School, founded thirty years ago, had constantly outgrown its accommodation and in spite of new buildings and extensions in recent years, the time was rapidly approaching when new and larger buildings would be required. The present students were not only pursuing their studies under almost ideal conditions, but they had every reason to be proud of those who had taught and were still teaching there. He recalled great men of old on the medical side of Guy's like Sir W. Gull, Sir Astley Cooper, Dr. Pavey, and Sir S. Wilks; and on the dental side, Joseph Fox, Thomas Bell, J. Salter, H. Moon, and Newland-Pedley, to whose foresight, sagacity, and persistent determination was largely due the foundation of Guy's Dental School. Of the present members of the Staff he would refrain from speaking, but he ventured to say that they were more than worthy successors of the great men who had preceded them. In the love of one's hospital there was something more than regard for buildings and teachers, and that was the spirit and tradition, invisible but ever-present, of self-sacrifice, comradeship, loyal co-opetion, patient investigation and humble seeking after truth. These traditions were, so to speak, a torch handed on to them by their *alma mater,* whose flame must not be allowed to die out, for, shining bright and held high, it would illumine many dark places in their lives, and cheer and inspire them in times of perplexity and difficulty. He coupled with the toast the names of Mr. Bonsor, to whom Guy's owed a great debt of gratitude, and Mr. Bromley, whom they were glad to welcome back from the Army Medical service.

Mr. H. Cosmo Bonsor said it was the last occasion on which he should have the honour of returning thanks as President of the Hospital, because on Monday he would resign that position in favour of H.R.H. the Prince of Wales. They would remember that King Edward was their first Royal President, and on his accession to the throne King George became their second Royal President. The new School Buildings were opened by King Edward with a memorable speech, and the Nurses' Home was inaugurated by King George, when Prince of Wales. It was only fitting to acknowledge the great benefits conferred by both Royal Presidents upon the Hospital and School. He need only remind them that Guy's Hospital was founded by Thomas Guy 197 years ago, and that his will, which was incorporated in an Act of Parliament of that date, was still the charter of the Hospital, and had stood the test of time without amendment. They heard talk of nationalisation of land, of industry and of voluntary hospitals, but he believed that so long as the traditions of Guy's were maintained according to the will of their founder, the prosperity of Guy's Hospital was assured.

The Dean (Mr. Bromley) said that when he looked at that gathering he felt that the success of their School was assured. It had been his privilege to admit as final students many who had been pupils of Guy's men, and who, they knew, had been efficiently trained. During the war the average entry of dental pupils fell as low as three or four per annum, but this month had seen an enormously increased entry of close on sixty. He alluded to the great loss sustained by the Dental School in the death of Mr. Pillin. They must, however, congratulate themselves on having a new member of the Staff in Mr. Doubleday. They knew they had the right men at the head of the School, and were confident that they would maintain the best traditions of the past.

Colonel E. B. Dowsett, D.S.O., proposed the health of "The Visitors."

Mr. Dolamore made a happy response, expressing the hope that Guy's would continue to prosper, as they were all members of one profession.

Dr. Fawcett proposed the health of Mr. Cosmo Bonsor, alluding to his long service to the hospital during a period in which the buildings had been altered and improved out of all recognition.

In response Mr. Bonsor said he was not going to resign his office as Governor, to which he was first elected in 1882, and he hoped to continue as Chairman of the School Committee.

Mr. J. Rhys Herbert proposed "The Chairman," referring to the success of the Dental Society under Mr. Hopson's Presidency. The genial personality of Mr. Hopson was unique, for it was not acquired, but natural. He was the staunch guardian of the junior, the excellent adviser of the senior, and the trusted friend of the qualified man.

The toast was drunk with enthusiasm and musical honours.

In reply Mr. Hopson spoke of the debt he owed to Guy's and to Guy's men for more than thirty years. It was the third time he had presided over that annual dinner. He proposed the health of Mr. F. B. Bull and Mr. Rhys Herbert, who had worked so hard and so successfully in making all arrangements.

In reply, Mr. Bull said that 245 acceptances had been received. He read letters regretting inability to attend from Viscount Goschen, Sir Cooper Perry, and said that apologies had also been received from Dr. C. Addison, M.P., Mr. Pennefather, M.P., Dr. L. Shaw, Mr. Colyer, and others.

During the evening Mr. J. Vale Lane's orchestra played selections; Mr. George Baker sang "Myself when young" and "Onaway, Awake"; Miss Alma Goatley gave songs at the piano; and Mr. Walter Newman and his pianist contributed a burlesque ballad.

Reviews, etc.

Mental Disorders of War. Jean Lepine.

This interesting and valuable book forms one of the series published under the term Military Medical Manuals. The author is a recognised authority on his subject, with a large pre-war reputation, so that his views and exposition are all the more acceptable to the learner. Throughout his book, one is never allowed to lose sight of the close connection which exists between the mental disturbances in peace and war. Certain minor differences there are—and these are placed in the right perspective. The relative increase which has been produced by war consist mainly of the acute forms. These are the result of fatigue of the higher psychic centres, leading to symptoms due to a temporary insufficiency of such psychic functions. Careful observation is usually needed for several days in such cases before definite mental disease—more especially the various forms of dementia—can be excluded from the diagnosis.

The rival claims of concussion and emotion as the predominating cause in confusional states will be found fully discussed. Perhaps undue prominence is given to concussion as an active ætiological factor.

An important section deals with those medical conditions where the mental condition is entirely a secondary one, and in which therefore careful clinical examination alone can give the true diagnosis.

The legal and military aspect of the war neuroses also receives ample consideration.

To any wishing to become acquainted with the Psychoneuroses—a subject which is of growing importance—this book will serve as a valuable Introduction.

Catalogue of Lewis's Medical and Scientific Circulating Library, including a classified index of Subjects, with the names of their authors who have treated upon them. Second edition. 8vo. (London: H. K. Lewis.) 492 pp. 12s. 6d. net. (Subscribers 6s. net).

Messrs. H. K. Lewis are to be congratulated upon this valuable and useful book of reference. This book contains upwards of 3,000 volumes with the year of publication and price of each book.

It consists of two parts, the first an alphabetical list of books in the library arranged under the names of the authors, the second a classified index of subjects, giving the names of the authors who have treated upon them.

The work has been carefully done, and represents a large amount of pains-taking labour.

In most instances where we tested a reference we fouud it correct. It is exactly the obscure book which is difficult to find, and contains an unrivalled list of modern medical and scientific text-books and special monographs, which no medical or scientific library should be without.

Elements of Surgical Diagnosis. By Sir Alfred and E. Pearce Gould. (Cassel & Co., Ltd.) 12s. 6d.

The appearance of a fifth edition of this well-known little book is sufficieht evidence of its continued popularity, and the authors have successfully brought it thoroughly up to date without any undue increase in size. The object of the book is to bring before the reader in an orderly manner the usual methods of clinical examination, and to endeavour to lead him from the signs and symptoms which the case presents to a logical diagnosis based upon his findings. It is no doubt impossible in a book of this size and nature to avoid a certain attitude of dogmatism, and if a perusal of this volume leaves one with a vain wish that diagnoses were in practice as certain and simple as the authors make it appear in some cases, the fault is no doubt with the reader rather than the authors. In this edition the figures in the text are replaced by additional radiograms which are excellently reproduced. The volume is full of interesting facts, and will undoubtedly be as widely read and appreciated in the future as it has been in the past.

Cricket Club.

GUY'S v. CHARLTON PARK.

The first game of the season took place on Saturday, May 10th, v. Charlton Park. The game ended in a very even draw. The Hospital team, though entirely experimental, yet performed very creditably, and there seems to be plenty of good talent available. At the same time there is room for great improvement, especially in the bowling line. We have drawn Bart.'s in the first round of the Inter-Hospital Cup, and every effort must be made to retain the cup, which the Hospital won from London in July, 1914. Scores: Guy's, 142 for 7 wickets.

S. Rose	5	H. Schapiro	4
T. Wooldridge ...	20	J. Wharton, not out	17
C. Vincent Brown ...	38	H L. Bernstein ...	9
J. D. S. Thomas ...	1	Extras	1
A. Jordon	32		
D. M. P. Whitcombe	15		142

Opponents' score, 190 for 8 wickets.

FIXTURES.

May 3	v. R.N. College, Greenwich	Home
10	v. Charlton Park	Home
14	Trial Match.	
17	v. Bromley	Home
29	Trial Match.	
31	v. Beckenham	Away
June 7	v. Charlton Park	Away
11	v. R.N. College, Greenwich	Away
14	v. Old Westminster's C.C.	Home
18	v. Sutton	Away
21	v. Old Citizens	Home
25	v. King's College School	Away
July 5	v. Beddington	Home
12	v. Beckenham	Home
18	v. Thespids	Home

ED.—G. B. D.

GUY'S HOSPITAL GAZETTE.

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Passim.

IT is becoming sadly evident that the War Memorial Fund will not reach anything like the sum that it has been considered reasonable to hope for. The reasons for this are not very clear; it may be that at a time when public calls for generosity are on every hand, the medical practitioner to whom the memorial must look for its main support has found that his resources are too heavily taxed to respond as fully as he would like to the needs of his Hospital Memorial. On the other hand, it may be that the proposals hitherto put forward as to the character of the memorial have not met with such a degree of enthusiasm as was originally hoped for. There are, of course, certain objections to the proposal set forth in the original appeal to grant free education at Guy's Hospital to the sons and daughters of those who have fallen or otherwise suffered in the war. For example, it appears that very few of those Guy's men who fell in the war were married, and as it is obviously undesirable to offer such a form of education as medicine to anyone without having careful regard to his natural tastes, it may be quite difficult to find suitable individuals to offer this particular form of benefit.

It is clear, therefore, that while the first care of the Memorial must be to assist, in whatever way may be found best, not necessarily by an education at Guy's, the children of fallen Guy's men who may be in need of assistance, the major portion of the funds must be devoted to some other purpose.

It has been suggested in these pages that the idea of a Hostel at Honor Oak Park for junior Guy's-men might meet with the approval of subscribers; we need only say that while the idea has received general support as a good project apart from the memorial, the suggestion that the funds of the memorial should be spent upon it has been received by many almost with hostility. We feel bound to acknowledge that this opposition is natural in view of the purely utilitarian nature of the scheme, and we do not propose to uphold the suggestion any further.

We venture here, however, to make a suggestion that we believe will appeal to a great number of old Guy's men. Our suggestion is that a portion at least of the funds of the memorial should be devoted to a new ward, one that would be in some way unique and worthy of the great object for which it was made—as beautiful as a ward can be made, and one in which it should be the special ambition of

every Guy's man to work. We suggest that our new Clinical Ward should be called the War Memorial Ward, and that upon its walls should be inscribed the names of all those whom we wish to commemorate. It would surely be fitting to honour the names of the fallen in a place where all the greatest traditions of the Hospital would be upheld.

We venture to believe that such a proposal would gain the fullest sympathy of the friends and relatives of those whom we wish to honour, whose names would in this way be remembered through a posterity that will always honour Guy's most famous men.

MANY old Guy's men are no doubt aware that Allen Bell was obliged last March to give up his post as Post Mortem Assistant, owing to a serious illness.

For many years Bell has been not only one of the most valuable servants the Hospital has ever possessed, but also unquestionably one of Guy's most popular and respected figures.

A subscription has been started to present him with a purse and testimonial. He is now an in-patient in one of the medical wards, and it is felt that it should be done immediately to show a little of the appreciation he richly deserves.

We therefore feel justified in asking all old Guy's men who knew Bell to send a small subscription towards his testimonial; we are sure that it will be a great pleasure to him to see the names of some of his old friends

Subscriptions should be forwarded to "The Allen Bell Testimonial Fund," c/o the Editor, Guy's Hospital Gazette. They should be sent as early as possible, as it is hoped to present the testimonial on Saturday, 21st June.

ONE of the notice-boards in the Colonnade lately contained the outlines of a proposed scheme for the formation of a London Medical Students Club, and a time and place were indicated where a discussion on this project would be held to see whether or not the proposal was one worthy of consideration. Though it is generally recognised that the last place to put an important notice is on a notice-board, we do not consider that this fact alone explains the extreme apathy which this proposal, originating at King's College and backed by several London Medical Schools, has met at Guy's. It has not been taken up because it sets out to create something which the vast majority of medical students do not want—a central social club. The medical student who from day to day is thronged about by hundreds of other medical students is asked to join a club where the great attraction is that he will meet yet many more medical students. The answer to this is plain and has been given.

But it is our view that to many this will be not so much a failure as a disappointment. To make any appeal to real enthusiasm, the activities of this project must be far more political and less merely social. Are there not possibilities in the unity of medical students?

We are reminded of the astonishing muddle which was made by the examination authorities last year in the matter of anatomical terminology. Here a united view of those who had to suffer from those blunders would have been of incalculable value. We feel confident that the view on that particular question was practically unanimous. It was the means of expressing that view which was lacking. That, in our opinion, is the gap to be filled up. The time has come when some means ought to be devised by which the general opinion of medical students could be ascertained on questions which vitally concern them.

And we venture to commend this to the promoters of the original scheme, that they may be induced to give up something which is lifeless and superficial for something that is a real necessity and will arouse much enthusiasm and support.

In this connection it will be remembered by many that in 1913 this desire for concerted action gave rise to periodical meetings of the Editors of the various Hospital Journals in order that they might co-operate in the treatment of certain questions of interest to medical students. This was a move in the right direction, but we believe it would not now be sufficiently representative to wield that influence by its decisions which could be obtained by a properly organised union of medical students. In view of the proposed changes in medical education we believe unity to be a clear necessity.

OUR heartiest congratulations to Dr. Herbert French who has received the C.B., also to Dr. A. F. Hurst and MR. E. C. Hughes who have both received the O.B.E.

WE are indebted to Sir William Osler for the following anecdote of Sir Astley Cooper, taken from the "Reminiscences" of George Coventry :—

"Speaking of the year 1818, when he was living in London, Coventry says :

'I also attended Sir Astley Cooper's lectures, having a particular friend, Doctor Ellerby, who took me under his protection. They were very clearly and beautifully delivered. On one occasion a man was laid on the table for the audience to witness the dexterity with which Sir Astley could cut off a man's leg. Whilst he was explaining some parts of the process, the man died: and there he lay. Sir Astley looked at him, and turning round said very composedly, "Our friend has left us, bring another." He went on with the lecture without any further comment, thus evincing to the students the necessity of a surgeon being calm and cool on all occasions.'"

Guy's War Memorial Fund.

	£	s.	d.
Amount acknowledged ...	3,576	6	8
Kirby, E. F.	2	2	0
David, W. W.	5	5	0
Kendall, N. E.	5	5	0
Mather, H.	2	2	0
Guy's Hospital Clubs' Union (Gate Money)	59	4	2
Cooper, H.	1	1	0
	£3,651	5	10

Guy's '89 Club.

The proposed Meeting and Dinner of the Club has been postponed until early in October. The usual notice will be forwarded to every member at the end of July, and it is hoped to have a record attendance. The Secretary, H. J. Spon, 61, Harley Street, W.1., will be glad to have the addresses of those members who are away on Active Service.

Erratum.

Our apologies are due to Dr. Geoffrey Marshall for a misprint in the account of the last meeting of the Physical Society in our last issue. Dr. Marshall is misquoted as having advised transfusion of six thousand to ten thousand c.c. of blood. The volume should of course be six hundred to a thousand c.c.

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Two Cases of Tuberculous Kidney.

OUTLINE OF A CLINICAL LECTURE BY RALPH THOMPSON, Ch.M., F.R.C.S.

THE first case shown was that of a healthy-looking male adult, æt. 49, who gave the following history. First he noticed that he was out of sorts and disinclined for exertion in May, 1918. These symptoms were followed by more definite sensations, such as dull aching pain in the bladder region, associated with frequency. The micturitions numbered about ten during the day and half a dozen, or so, during the night. The nocturnal frequency rather suggests that the formation of a vesical calculus need not be considered. The water then became thick, from which we may assume that there was some pyuria. He was treated for cystitis by repeated irrigations, which relieved the pain somewhat. In January, 1919, he passed blood, and saw black clots of blood in his urine, and in the vessels into which he micturated.

The bladder was examined by means of a cystoscope. There were two or three circinate inflamed patches at the apex of the bladder. These patches could be traced towards the right ureteric orifice which was large, excavated, and had its margins rounded and heaped up. It was quite inactive. The left ureteric orifice was normal. Farciculation of bladder wall was present, but not in extreme degree.

Upon this cystoscopic evidence I was led to suspect tuberculous disease of the right kidney, and, on palpation, of the right renal region, I thought I could feel a swelling, which I considered was probably an enlargement of the right kidney. I communicated my suspicions to the patient, and he then informed me that tubercle bacilli had been found in his urine by a competent authority. The diagnosis then was clear, namely, tuberculous disease of the right kidney, and the only treatment was extirpation of the right kidney, provided that the left kidney was healthy which, according to the appearance of the left ureteric orifice, it was. I pressed operation, but the patient was a little unwilling to undergo one. However, in May, 1919, the symptoms recorded above getting worse, he consented to operation. But we had still to make clear that the left kidney was not diseased.

I am not sure that one should catheterise the ureter in such cases for the purpose of analysing the urine from that kidney. The question of thus catheterising a healthy-looking ureter is a very difficult one, especially when the bladder through which one passes the catheter is tuberculous. Dr. Ryffel reported that the urea contents in the blood was normal. I felt greatly cheered by this report, as in my opinion a tuberculous kidney which is palpable, without being associated with undue mobility, is a worthless organ; and, if this statement be true, then the total renal function was being adequately carried out by the left kidney.

A second cystoscopic examination was carried out and the following observations were made. The urine was very dark coloured, ? blood intimately mixed. The baldder was repeatedly irrigated with 2 oz. of warm water, and when this ran clear, 6 oz. were left in the bladder and the cystoscope passed. Left ureter normal and admitted ureteric catheter, which was passed easily and well, and when in the pelvis of the left kidney discharged clear urine at a normal rate. The parts surrounding the left ureter were healthy. Right ureter surrounded by small tuberculated ragged masses, bleeding easily. Ureteric catheter passed into

large excavated orifice, corresponding to position of right ureter, but only for 2 cm.

It was pointed out to the patient that in all probability the left kidney was healthy, the right kidney was worthless, and actually harmful as being a source of infection; and feeling, as he did, much worse than he had done previously, he consented to an operation.

Our second cystoscopic examination had shown us that the right ureter was impervious to the catheter which we had attempted to pass along it, and I therefore considered that the right ureter was probably extensively diseased. I thought the case a very suitable one for an operation which was first recommended by Mr. Joscelyn Swann. The principle in the operation is the exposure and ligature of the ureter by an abdominal, but extraperitoneal incision by one incision, and by a second lumbar incision, to remove the kidney. The incisions are separated by a bridge of muscular and cutaneous structures some two or three inches in length. It is suggested that this operation reduces the liability to hernia to a minimum.

The patient was given C.E. and chloroform by Mr. A. D. Marston, and stood the administration well. He was laid on his back, and an incision was made on the right side beginning one inch above and internal to right anterior superaspina, and extending downwards and inwards for four inches. The external oblique and deep muscles were divided in the direction of their fibres, as also the transversalis fascia, and the peritoneum was exposed and turned well forwards. When the bifurcation of the common iliac artery was reached, the ureter was searched for, and found on the posterior aspect of the peritoneum, where it is usually to be discovered. It was thickened and pale in colour. Two ligatures were applied some half inch away from each other and as low down as possible. The ureter was divided between the ligatures and its divided ends were touched with pure carbolic acid. The wound was then sewn up.

The patient was then turned on his left side, and the right kidney exposed in the usual way. It was found to be tuberculous, and removed with the ligatured ureter. The vessels were not thrombosed, and bleeding after division of the pedicle subsequent to its ligation was a little inconvenient, but eventually arrested. The bridge of undivided tissue between the two wounds was very much in the way, and, of course, could not be divided in order to make more room for removal of the kidney, as the total length of the two wounds, if thrown into one, would have been over 16 inches. I shall not perform this operation again.

The patient was discharged about one month after the operation. I had a little anxiety about the lower wound, and on his discharge there were signs, decreasing, it is true, in intensity, of an abscess having formed, but the signs were not very pronounced, and I have great hopes now, after his discharge, that we may have been deceived.

The points to be observed about the case are—

1. The age of the patient, 49.
2. The frequency of micturition.
3. The apparently healthy condition of the patient.
4. The absence of renal localising symptoms.
5. The cystoscopic appearance of extensive tuberculous disease of the bladder grouped around the orifice of the right ureter.
6. The steady progress downhill of the patient between January and May, 1919.

Before passing on to the next case I should like to say that, after I had perused several post-mortem reports which had been made by Sir Cooper Perry, it was perfectly clear to me that he had recognised before anyone else that tuberculous disease of the bladder was always secondary to either renal tuberculosis or tuberculosis of the genital tract, and to him the

credit of this discovery should be given. What the writer owes to Sir Cooper Perry in this matter has been often most useful to himself as well as, he hopes, to others. He would here ,and now, like to offer to Sir Cooper Perry his gratitude and thanks for his teaching on tuberculous disease of the bladder, as well as on many other "urinary matters."

The next case is that of a patient, a healthy-looking male adult, under the care of Dr. Price of Bromley. I append the report of the ward clerk, Mr. M. Maizells: The patient was under the care of Dr. John Fawcett in Guy's Hospital. T .D., aged 50. Admitted for frequency of micturition. Family history does not bear upon case. Has been operated upon for varicose veins, and suffers slightly from bronchitis. Frequency of micturition for six months previous to admission, six times by day and twice by night. This frequency has increased to once every half hour by day and once every hour by night. Some pain on micturition in middle of penile urethra. Hypogastric pain developed later, which is independent of micturition. The urine has been brown or red at intervals. The flow of urine is often dribbling and sometimes forked. Apparently he has had one attack of retention for which a catheter was passed and effected relief.

So far, then, we have a case suffering apparently from cystitis. Pulse 80, temperature 98·4°, respiration 20. Weight 8 st. 10 lb. 8 oz. which is less by a good deal than the patient should weigh.

On examination the only positive point of value was that the lower pole of the right kidney was unusually palpable. I suggest that this might be evidence of compensatory hypertrophy, although in my experience such kidneys as are hypertrophied may give rise to pain, yet they are not, as a rule, easily palpable. Both epididymes were enlarged and hard, but especially the lower pole of the left epididymis, which was nodular and hard. No thickening of the cord could be detected. R.E. negative.

Dr. Ryffel was of opinion that the right kidney was not compensating sufficiently for the inactivity of its fellow. The urine contains red cells, pus cells and albumin (vide infra). I cystoscoped the patient, and found extensive tuberculous ulceration of the bladder. The patient was X-rayed and the whole of the left kidney is opaque.

Dr. Fawcett agreed with me that the patient had tuberculous disease of the genito-urinary tract, and the question which had to be solved was this—does operation afford any prospect of relief to the patient? He was suffering from very frequent micturition and a good deal of pain. I considered very carefully Dr. Ryffel's report, and he told us that the albumin was in excess of that of pus and blood. This point rather led me to conclude that there might be a toxic nephritis in the right kidney which might actually be improved by an operation, and I think that Dr. Fawcett agreed with me that the only chance for prolongation and amelioration of life lay in an operation. He very kindly transferred the case to my care, and I operated upon the patient on Tuesday, June 10th. Dr. Shipway was kind enough to give the anæsthetic, partly because I wanted the patient to have the best chance possible from the point of view of shock and partly because the bronchitis which was recorded previously in the history might have had a tuberculous basis.

The left kidney was cut down upon, found to be small, and was removed after ligature of the pedicle. Great care was taken not to nick or burst the obvious and thin-walled purulent swellings in it.

The testicle on the left side was next removed, and the cord was found to be extensively involved. This was ligatured after exposure and the testicle removed; the actual

cautery was applied to the stump of the cord. Patient did well immediately after the operation.

I have merely published this case as I wish to shew that frequency of micturition may be practically the only sign of a very extensive tuberculous lesion. I will, with the permission of the Editor of the GAZETTE, publish the remote result later.

NOTE.—When the kidney was incised for examination after removal it was found to be divided into about 12 cantica containing inspissated pus and some stones, ? phosphatic. There was no true kidney tissue left at all. Also it should be noted that, although there was so much disease of the left testicle and cord, there was very little pain or tenderness, and compared with the actual lesion very little to be palpated.

Appointments.

R.A.M.C.

Act. Maj. R. L. Rankine relinquishes acting rank of Major.

To be Capt.—Lieut. W. D. Newland.

Capts. P. C. Litchfield and J. F. H. Stallman relinquish their commissions and retain the rank of Capt.

R.N.M.S.

Surg.-Lieut.-Commanders to be Surg.-Commanders—F. C. Robinson, C. H. Dawe.

Surg.-Lieut. to be Surg.-Lieut.-Commander.—R. Rankine.

Civil.

J. Magnus Ridding, M.R.C.S., L.R.C.P., to be Senior Surgical Radiographer, Guy's Hospital.

Lieut.-Col. A. F. Hurst, M.D., F.R.C.P., R.A.M.C has been appointed War Office Representative at the Congress of the American Neurological Society to be held at Atlantic City, June 15th, 1919.

Dr. Maurice Craig has been appointed Honorary Consulting Physician (Neurological) to the Ministry of Pensions.

Pass List.

University of London.

THIRD M.B., B.S. EXAMINATION FOR MEDICAL DEGREES.

May, 1919.

Honours.

*L. S. Debenham. †A. E. Sawday.

*Distinguished in Medicine and Pathology.

† " " Surgery.

Pass.

G. D. Eccles. Maitland Scott. C. Sherris.

Supplementary Pass List.

The undermentioned passed in one of the two Groups:—

Group I.—E. F. Kirby, H. W. Southgate.

" II.—E. D. Scott.

Honours.

BIRTHDAY HONOURS.

K.B.E. (Military Division).

Surg. Rear Admiral W. W. Pryn, C.B., R.N.

C.M.G.

Lieut.-Col. C. G. Douglas, M.C.

Lieut.-Col. (Temp. Col.) W. P. Gwynne, R.A.M.C

Change of Address.

Lieut.-Col. F. E. Fremantle, Bedwell Park, Hatfield Herts. (Tel. Essendon 14.)

B. S. Samuel, 18, Wimpole Street, W. 1. (Tel. Pad d 2241.)

Surg.-Com. Douglas G. Mitchell, R.N., c/o Alverstone House, Shanklin, I.O.W. (temporary).

H. Millett, 63, Alexandra Road, St. John's Wood, N.W. 8.

Ralph Thompson, M.Ch., F.R C.S., 45, Queen Anne Street, W. 1.

Lieut. F. H. Wallace, R.A.M.C.(D.), Officer's Mess, Embarkation Rest Camp, Southampton.

Surg.-Lieut. C. T. Helsham, R.N., H.M.S. *Canada*, c/o G.P.O., London.

Oswald Marriott, M.D., B.S., has returned to Hong Kong, China.

Capt. V. P. Webster, R.A.M.C., Ty Gwyn, Merthyr Tydfil.

R. Curle, "Musgrove," Christchurch Road, Bournemouth.

A. R. Thompson, F.R.C.S., from 49, Wimpole Street, to 45, Queen Anne Street.

Dispensary and Pharmaceutical Laboratory Report, 1918.

The number of Out-Patient attendances at the Dispensary during 1918 was 179,824 as compared with 168,084 in 1917; 182,905 in 1916; 172,062 in 1915; and 176,973 in 1914.

These are classified for the last two years in the Table below, from which it will be seen that 94·2 per cent. of the Out-Patients paid the nominal sum of 3d. for their medicine as compared with 90·9 per cent. in the previous year.

NUMBER OF DISPENSARY ATTENDANCES.

1918.	Medical.	Surgical.	Casual.	Total.
Paying ...	76,409	33,263	59,772	169,444
Free ...	3,024	1,917	5,439	10,380
	79,433	35,180	65,211	179,824
1917.				
Paying ...	68,603	31,826	53,437	153,866
Free ...	3,775	2,566	7,877	14,218
	72,378	34,392	61,314	168,084

The Receipts have been as follows:—

	1918. £ s. d.	1917. £ s. d.
Out-Patients	2,129 14 10	1,914 19 2
Sale of Drugs	110 3 6	114 7 5
Net Profit on the Sale of Bottles to Out-Patients...	88 0 9	54 6 7
Goods supplied to the Medical School...	119 12 4	102 14 9
Goods supplied to the Dental School	37 12 2	42 18 9
Goods supplied to the Guy's Hospital Trained Nurses' Institution	12 12 3	12 1 2
Medicines and Dressings supplied to the Nursing and Domestic Staff ...	56 12 4	85 0 5
Salvarsan Substitutes supplied to Outside Practitioners	238 5 6	53 10 0
Total ...	£2,792 13 8	£2,379 18 3

Goods supplied to—	1918. £ s. d.	1917. £ s. d.
Surgical Skiagraphic Dept.	19 3 4	9 8 10
Medical " "	49 17 4	40 3 11
Actinotherapeutic "	6 13 1	7 13 2
Massage "	1 0 0	1 14 0
Works "	3 6 7	5 10 6
Post-mortem Room ...	4 14 0	3 4 4
Bacteriological Dept. ...	25 8 2	21 4 0
Pathological " ...	15 6 10	9 19 5
Clinical Chemistry Dept....	7 12 1	7 10 10
Sterilising Room	19 14 6	11 7 6
Total	£152 15 11	£117 16 6

ANÆSTHETICS. Quantity purchased.

	1918	1917	Cost. 1918 £ s. d.	Cost. 1917 £ s. d.
Absolute Alcohol	104 lbs.	80 lbs.	42 3 6	21 17 4
Chloroform	4 cwt.	672 lbs.	94 14 8	109 4 0
Ether	1,472 lbs.	1,578 lbs.	223 6 8	216 19 1
Nitrous Oxide Gas	56,000 gals.	45,500 lbs.	138 15 0	79 12 6
Cocaine and its Salts	3 ozs.	6½ ozs.	3 17 6	9 12 0
Novocaine			—	3 11 6
		Total ...	£502 17 4	£440 16 5

ANTISEPTICS. Quantity purchased.

	1918	1917	Cost. 1918 £ s. d.	Cost. 1917 £ s. d.
Acid, Boric	14½ cwt.	26 cwt.	55 3 8	79 8 0
Acid, Carbolic	6 "	11½ "	47 3 0	85 5 8
Formaldehyde	442 lbs.	784 lbs.	43 6 8	35 0 0
Hydrogen Peroxide	840 gals.	825 gals.	247 1 8	191 7 6
Iodoform	20 lbs.	11 lbs.	19 18 4	9 1 0
Iodine	28 lbs.	70 lbs.	22 15 0	54 7 4
Cresol	501 gals.	522 gals.	74 1 9	71 15 6
		Total ...	£509 10 1	£526 5 0

SERA.

	1918 £ s. d.	1917 £ s. d.		1918 £ s. d.	1917 £ s. d.
Anti-Anthrax	8 18 9	49 10 6	Anti-Colon Bacillus ...	2 2 0	—
Anti-Diphtheria ...	87 3 0	51 0 0	Normal Horse ...	2 14 0	3 3 0
Anti-Meningococcus ...	10 5 4	8 7 6			
Anti-Tetanus	18 0 0	34 13 6	Total ...	£230 5 1	£180 18 5
Anti-Streptococcus ...	101 2 0	34 3 11			

SALVARSAN SUBSTITUTES PURCHASED.

	Doses. 1918	Doses. 1917	Cost. 1918 £ s. d.	Cost. 1917 £ s. d.
Arsenobillon	10	410	5 0 0	95 14 0
Novarsenobillon	2,070	2,090	296 12 6	303 14 6
Kharsivan	—	30	—	7 14 6
Neo-Kharsivan	672	24	100 16 0	4 10 0
Galyl	1,076	282	279 1 9	74 8 9
Intramine	4	29	1 10 0	8 13 2
Di-Sodo-Luargol	475	173	46 17 5	21 19 8
Neo-Divarsenol	196	—	33 0 0	—
Total			*£762 17 8	£516 14 7

*Including substitutes to the value of £238 5s. 6d. supplied to outside Practitioners.

Collosol Iodine	16 W. qts.	6 W. qts.	£24 15 0	£6 15 0
Yadil	19½ gals.	—	34 7 6	—

QUANTITY PURCHASED.

	1918	1917	Cost. 1918 £ s. d.	Cost. 1917 £ s. d.
Bismuth Salts	98 lbs.	130 lbs.	73 6 6	80 14 2
Camphor	112 lbs.	245 lbs.	23 16 0	33 12 10
Glycerin	—	—	—	—
Glucose Liquid	28 lbs.	20¼ cwt.	1 17 4	47 8 4
Honey	—	18 cwt.	—	70 8 6
Lard	—	—	—	44 11 5
Malt Extract	165½ cwts.	130 cwt.	476 0 6	316 10 0
Oil, Cod Liver	100 gals.	350 gals.	25 0 0	77 0 3
„ Cotton Seed	—	82 gals.	—	26 14 0
„ Linseed	12½ gals.	172¼ gals.	5 14 9	38 1 2
„ „ Fatty				
Acids	16 cwt.	—	62 16 3	—
Oil, Olive, Commercial	—	202 gals.	—	82 11 8
„ „ Sublime	—	70 gals.	—	40 5 0
„ Sesame	44 gals.	—	30 4 4	—
„ Soya Bean	—	28 lbs.	—	8 3 2
Oxygen...	—	—	99 3 3	75 2 5
Paraffin Liquid	370 gals.	209½ gals.	253 16 4	183 3 1
Potassium Iodide	129 lbs.	238 lbs.	89 10 6	126 18 8
Spirit, Methylated	500 gals.	900 gals.	210 4 2	323 10 0
„ Rectified	100 gals.	75 gals.	250 12 6	133 2 6
Sugar	10½ cwt.	262 lbs.	30 18 9	6 2 3
		Total ...	£1,633 1 2	£1,713 19 5

DRESSINGS. Quantity purchased.

	1918	1917	Cost. 1918 £ s. d.	1917 £ s. d.
Bandages, Crêpe	21 doz.	36 doz.	10 1 0	10 4 9
" Grey, 1½ in. by 6 yds.	31¼ gross	90 gross	10 10 11	27 0 10
" " 1½ in. by 3 yds.	64½ "	—	26 12 2	—
" " 2½ in. by 6 yds.	125 "	531 gross	68 15 0	273 12 8
" " 2½ in. by 3 yds.	352 "	—	225 18 8	—
" " 5 in. by 6 yds.	164 "	161 gross	260 4 9	172 19 3
" White, 1½ in. by 6 yds.	10 "	60 "	7 5 0	20 13 4
" " 2½ in. by 6 yds.	130 "	140 "	140 15 0	78 10 0
" " 5 in. by 6 yds.	90 "	160½ "	183 0 0	181 4 5
Bandages, Cloth	25,476 yds.	27,636 yds.	509 1 5	263 17 0
Cellulose Wadding	56 lbs.	56 lbs.	3 10 0	1 19 8
Felt	11 lbs.	56¾ lbs.	6 12 11	25 18 5
Gauze Cyanide	10,020 yds.	18,540 yds.	67 8 8	77 11 1
" Grey	32,544 yds.	32,856 yds.	170 19 4	96 18 9
" Iodoform	5,412 yds.	4,608 yds.	40 7 0	23 0 10
" Ribbon	150 doz.	168¾ doz.	39 3 6	25 5 6
" White	4,100 yds.	5,006 yds.	30 16 9	40 11 1
Lint	57 cwt.	89 cwt.	919 2 0	721 10 0
" Boric	8 cwt.	12 cwt.	105 0 0	90 1 4
Oil Paper	3,960 sheets	3,400 sheets	12 0 10	6 2 6
Strapping Rubber	45 doz.	46 doz.	45 9 3	39 7 6
Tow	6 cwt.	10 cwt.	13 0 0	15 8 0
Wool, Absorbent	70 cwt.	70 cwt.	693 0 0	389 13 4
" Grey	40½ cwt.	39 cwt.	285 11 4	116 4 2
Wool and Gauze Tissue	168 lbs.	112 lbs.	20 6 0	7 0 0
Gutta Percha "	98 lbs.	76¾ lbs.	34 13 0	23 8 2
		Total ...	£3,929 4 6	£2,728 2 7

PHARMACEUTICAL LABORATORY.

The work of this Section has included the following:—

	1918	1917		1918	1917
Collodions	1½ gal.	2 gals.	Syrups	150 gals.	200 gals.
Confections	1 cwt.	1 cwt.	Tablets, Compressed ...	3½ cwt.	3 cwt.
Dentrifices	16 lbs.	16 lbs.	Tinctures and Liq. Extracts	225 gals.	240 gals.
Extract Malt Ferral ...	66 cwt.	—	Soda Water	9,500 syphs.	16,000 syphs.
Ext. Malt with Ol. Morr. ...	71 cwt.	—	Cresol and Soap	850 gals.	1,000 gals.
Liniments	100 gals.	110 gals.	Iodine Pessaries	662	—
Mixtures, including Emulsions, 340 gals.... ...	9,500 gals.	6,500 gals.	Sulphur	1,900	—
Ointments	31 cwt.	35 cwt.	Jellies	174	—
Plasters	2,000 yds.	2,000 yds.	Methyltd. Spirit Recovered	30 gals.	—

The cost of Drugs and Dressings during the last two years is given below, the figures being obtained from the Clerk to the Governors.

	1918 £ s. d.	1917 £ s. d.
Drugs	5,836 4 10	3,870 17 2
Dressings	4,113 12 7	2,427 14 10
	£9,949 17 5	£6,298 12 0

Nursing News.

The Matron's Office,
May, 1919.

During the present month three very successful functions have taken place of great interest to all past and present Guy's nurses, which we have much pleasure in reporting.

NURSES' BAZAAR AND FETE.

This was held at Devonshire House on May 1st, 2nd and 3rd, and was arranged and promoted by the ladies in charge of the Nation's Fund for Nurses. Viscountess Cowdray is the hon. treasurer of the fund, which has for its primary object the assistance of all nurses in sickness and distress.

Lady Perry was chairman of the Bazaar Committee, and Lady Fripp kindly undertook charge of the Guy's stall and also wrote to the Governors of the Hospital soliciting their help. Miss Sheldon did the same to the members of the Hospital Medical and Surgical Staff. In this way, through Lady Fripp's untiring energy and the personal generosity of the Governors and the Medical and Surgical Staff, the Guy's stall was able to hand over £500 to the Tribute and Benevolent Fund.

The Bazaar was very successful and was visited by Queen Alexandra and Princess Victoria. The Matron, Sisters and Nurses were present each day. We wish to take this opportunity of thanking most sincerely all who sent donations and gifts, and also Lady Fripp and all those friends who personally assisted at the stall.

The Nation's Fund for Nurses, although but recently established, is doing noble work. The offices of the fund are at 32, North Audley Street, W. 1, where information and literature can be obtained.

THE MEETING OF THE LADIES' ASSOCIATION.

This meeting was held in the Court Room on Monday, May 19th. To the Matron, Sisters and Nurses of the Hospital the Association stands for much personal interest in their work. The visits to the patients and the garments supplied are a source of great pleasure and utility, and a valuable addition to the linen stores of the Hospital. The Association also supports eight beds in Victoria Ward, and cots in Esther and Lydia, a fine piece of work which is gratefully acknowledged by the Governors in their Annual Reports. The meeting this year was presided over by Dame Sarah Swift, who received many congratulations upon her honours. Very great regret was generally expressed by all present as it was the last appearance of Mrs. Lauriston Shaw as the Hon. Secretary.

Founded in 1895, Mrs Shaw has worked indefatigably for the Association, and has earned the affection of her fellow workers and the gratitude of the Hospital. Associations on the same lines, both at home and abroad, have been established where ever Guy's trained women have obtained Matronships. In that way the pleasure of receiving the gifts that delight the Ward Sister's heart, and through hers the Matron's, has spread beyond the confines of Guy's.

Mrs. Philip Turner has been appointed Hon. Secretary, and we extend to her a most hearty welcome, and we are sure that the work will give her both interest and opportunity.

THE PAST AND PRESENT NURSES' LEAGUE.

On May 23rd the Annual Meeting and Dinner was held in the Nurses' Home. As an "Armistice Dinner" it was an occasion of special pleasure and was very well attended. Two hundred were present at the dinner and many more at the meeting afterwards.

The exhibitions of photographs and needlework, in abeyance during the war, were delightfully to the fore and much admired in the various sitting-rooms, prizes having been kindly presented by Mrs. Cosmo Bonsor, Lady Hale White, the Countess of Bective, Lady Henry Bentinck, Miss Bromley, Mrs. Chapple, Mrs. Fawcett, Miss Webster and the Matron.

Miss Enid Newton took the chair at the meeting and opened an amusing speech with offering the hearty congratulations of all present to Dame Sarah Swift, the guest of honour, upon the wonderful success of her work as Matron-in-Chief to the Joint Committee of the Red Cross Society. Miss Newton delighted all present with an account of her work in Egypt, including the desirability of travelling with a passport, even if you are military, the difficulties that can be caused with a superfluity of baths, and the deep-rooted conviction of the absolute impossibility of handing over to another matron a hospital ship containing (was it?) three hundred unmade beds! Our readers may rest assured that the C.O.'s suggestion "that it did not matter" carried no weight.

The Matron gave an account of the work of the League during the year, and spoke of the splendid service of Guy's nurses during the war and the honours obtained. In view of the publishing of a new edition of the Nursing Guide in the early autumn, she begged all to send in to the Matron's Office full particulars of their work and a *permanent address* for the Register.

Miss Hogg had a special announcement to make which will give great joy to many present and future Guy's nurses. As a memorial of all that has been done by the nursing staff in the service of the sick and wounded at home and abroad, and also in the routine work of the Hospital during the difficult war years, two of the Governors have given the sum of £2,000 to be expended upon the enlargement of the Nurses' Cottage at Honor Oak Park and the beautifying and stocking of the pretty grounds. We hope at a future date to publish a photograph of the cottage.

It is a real boon to the nurses, and this much wanted addition will make all the difference to the pleasure it can give in so greatly increasing its capacity. On hearing such a delightful piece of news all the past members immediately wished "their day" could come over again.

At the close of the meeting there was much conversation and general exchange of war work experiences and news in general. Many inquiries were made about Miss Haughton, and everyone was delighted to hear that her health has improved tremendously, and although still advised to remain at her temporary home at Chobham, she sees many old friends and is keenly interested in all that concerns the Hospital, and is delighted to hear from the nurses she knew.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—Being so far away, I fear that anything I say with regard to the Guy's War Memorial will arrive too late to have any influence whatever; nevertheless, I cannot refrain from protesting against the suggestion that it should assume a utilitarian form such as a lodging house for future Guy's students. Not only at Guy's, but in many other places, communities are proposing to give themselves presents and call them memorials to their dead. Nothing could be farther from the true spirit of a memorial. It is little enough we can do for those who have sacrificed themselves, but we can remember them and try to live realising what we owe to them. A monument reverently built will help us so to do. The wise peoples of the past, including our ancestors who built our cathedrals knew this. Therefore it is right and fitting that our memorial should take the form of a sacred building—a monument. The graves of Guy's soldiers, too, should be our especial care. So doing will help us to remember our duty to the dependents of the fallen and afflicted, and every Guy's man must feel that as long as the need exists it is his bounden duty to contribute to their assistance to the limit of his resources.

The money now collected must be used for a monument, to maintain the graves, and for some scholarship, not necessarily at Guy's, for the sons and daughters of our war victims. Over and above this we must establish a fund and keep it going as long as war dependents exist. Surely nothing will guide those who are responsible for the form this memorial is to take better than to keep ever before them the idea conveyed by those altruistic words, "Dare quam accipere."—Yours faithfully,

H. F. B.

Bedford C.P.,
24th April, 1919.

DEAR SIR,—I take the liberty of troubling you with a few lines in reference to the most interesting clinical lecture upon Influenza by Col. H. French that appeared in your issue of April 19th, as I think the following remarks may be of interest to your readers.

In reading Col. French's article I was specially interested to see that he refers to the "albuminous exudate" which is "very similar to that which can be seen in fatal cases of poisoning by chlorine gas" (page 122). Then on page 124 that "active treatment for the condition has so far been a failure." He follows this observation by mentioning the advantage resulting from the administration of unrestricted draughts of water.

It is these foregoing remarks of the lecturer which lead me to mention a form of treatment which I am convinced was of great value to the patient.

While in France in the spring of 1917, a great number of "gassed" cases passed through the hospital to which I was attached. After a very short while we became so much accustomed to the "appearance" and type of respiration of these cases that we could tell, without any stethoscopic examination, which cases would end fatally.

The careful study of the thoracic viscera at the autopsy led us to the conclusion that these men were really "drowned" by a toxic exudate and not in any way dying from another pulmonary condition or from heart failure.

Those in charge of the cases could do nothing and the bad cases were just left to die—so far as active treatment was concerned, I mean, of course. From our observations at the post-mortem we felt convinced that if this toxic fluid could be diluted good results might follow, and certainly no harm could come. After a good deal of opposition we persuaded those in charge to allow us to administer saline intravenously. The result was most remarkable. A severe rigor resulted, followed by a decided fall in temperature, and a second rigor and still further fall followed, and in some cases a third took place. Thus, in cases pronounced absolutely beyond hope, one often had the temperature reduced to normal within from six to twelve hours, and recovery resulted.

These experiences led me to attempt the same line of treatment in several cases of influenza during the recent epidemic with most favourable results.

To digress from the matter under discussion, I may add that I was tempted to use intravenous injections of saline to a considerable extent in cases of pneumonia also while I was temporarily placed in charge of the acute medical wards of one of our Military Hospitals at Home, on the assumption that the toxic process could thereby be minimised.

Out of many cases treated in this way I am pleased to say that only one case ended fatally—an extremely severe case in which the patient, a New Zealander, was delirious and almost pulseless before I was asked to see him—in this case the man survived for 13 days, which I am bound to think was partly, at least, attributable to the saline injections, as he showed signs of improvement on several occasions, unfortunately only to relapse at last.

I must apologise for troubling you at this length, but I have felt for so long that this simple method is so often not taken advantage of as it might be, nor have I read any article advocating its adoption.

Whilst in the Service I did not see the medical periodicals, I must confess, so if I have referred to a treatment already advocated pray forgive me.

Believe me, Sir,

Your obedient servant,

F. HOLCOMBE FULLER, M.R.C.S., &c.

28, Old Steine, Brighton. Late Capt., R.A.M.C.

29th May, 1919.

A Case of Cerebral Abscess following Acute Mastoid Disease.

Catherine C., married, aged 24 years, was admitted into Ruth ward in September, 1918, with symptoms of acute otitis media and possibly some intracranial complication. However, after myringotomy and treatment had been carried out, everything cleared up to such an extent that the patient discharged herself for domestic reasons at the end of three days. She did not attend Out-Patients, but on the night of March 3rd, 1919, came to the Surgery and was again admitted. She complained of great pain and tenderness over the left mastoid region. Temperature 98°, pulse 94, respiration 24. She had not vomited, but was apparently very ill.

The following morning she had severe headache, vomited and had a rigor. Temperature 102·8°, pulse 124. She had a meningeal cry and was comatose, but had no head retraction. Mr. Mollison operated and found pus in the left mastoid and an extradural abscess in the middle fossa. After painting the dura mater with pure carbolic acid, the temporo-sphenoidal lobe of the brain was explored, but nothing was found. The lateral sinus was normal. Lumbar puncture gave cloudy cerebro-spinal fluid under pressure, but no micro-organisms were detected. 10 c.c. of antistreptococcal serum were given subcutaneously.

Next day the cerebro-spinal fluid was still cloudy and under pressure. A further 10 c.c. of serum was given intrathecally. The pulse was very irregular and the rate decreased from 120 to 80 after lumbar puncture. As the patient still remained somewhat comatose and the pulse rate slowed gradually to 58, the posterior fossa was explored on March 7th, but nothing was found. The patient was put on to Carrel-Dakin treatment, two-hourly flushings being employed. During the following week there was some improvement; the cerebro-spinal fluid became normal, the pulse averaged 60, and the temperature about normal.

On March 17th she became worse and the pulse rate fell as low as 50 for the next three days; the temperature became definitely subnormal and the patient vomited frequently. Hemiparesis of the right side was definite, the knee-jerk was very brisk and the plantar reflex was extensor. Mr. Ormond examined the eyes, but found no evidence of optic neuritis. On March 21st a large abscess in the brain was discovered, which admitted the little finger to the region of the fissure of Rolando. Next day the paresis had completely gone and the patient was considerably better. The pulse rose at once to 90 and the temperature to just above normal.

Cerebral hernia resulted which occluded the drainage of the abscess cavity on two occasions and was cut away without any ill effects. Improvement continued until March 27th, and the patient was better then than at any other time in the hospital. However, 48 hours later the temperature went up to 100·2° and the pulse to 120. Hemiparesis again became noticeable, and the next day the patient was exceedingly comatose.

The brain was again explored, but nothing was found. Cerebro-spinal fluid was under pressure and very cloudy. It was afterwards found to contain pus, but no micro-organisms. 25 c.c. antistreptococcic serum was given this time intravenously. However, the patient developed Cheyne-Stokes' breathing and died the following day, with a high degree of pyrexia and a rapid pulse rate.

Post-mortem.—A diffuse collection of pus was found deep to the pia mater, especially on the under surface of the cerebellum and the left temporal lobe of the cerebrum. A large shaggy-walled cavity on the under surface of the left temporal lobe was clean, but the brain outside the area was inflamed. A small hole connected the abscess cavity with the lateral ventricle in the inferior horn. The liver was soft and friable, due to acute fatty degeneration. Cultivations of the pus under the pia and also from the mastoid cavity gave a pure growth of streptococcus longus. The cause of death was acute septic meningitis following the connection between the abscess cavity and the lateral ventricle.

Comments.—Is it likely that the acute attack in September, 1918, meant the onset of the extradural abscess? Extradural abscess on the middle fossa is much less usual than on the posterior fossa, and frequently points to an intracranial complication.

Carrel-Dakin treatment gave excellent results considering the whole case, as the abscess cavity was remarkably clean when seen at the post-mortem examination.

I am greatly indebted to Mr. Mollison for his valuable suggestions and also for permission to publish the case. W. R. C.

Cricket.

GUY'S v. ST. BART'S.

1ST ROUND LONDON HOSPITALS CUP.

Played at Hale End on Friday, June 6th. Result—Guy's won by 1 wicket and 45 runs.

Favoured by glorious weather, Guy's (the holders) and Bart's. met on London Hospital's ground to decide who should enter the Second Round of the Hospital Cup. Melle was the most prominent player on the Bart's. side, contributing nearly half of our opponents' score.

It looked as though Bart's were well set for a huge score. At lunch time they had registered 172 for 5 wickets. Mellie was missed when he had made 38, and profitting by the mistake added a further 60. However, after lunch a sudden and unexpected change came over the game—Shaw and Biddle dismissing the remaining five batsmen for 15 runs. Lindsay made two brilliant catches in deep field.

Guy's opened disastrously, three of the leading batsmen were out for 11, and over half the side dismissed for 85. However, when Rose joined Shaw—it was undoubtedly the turning point of the match—both players played very safe cricket and carried the score to 125. Helder joined Harris at the 8th wicket, and the pair added another 100 to the score, at the same time securing the necessary runs to enter the 2nd round. It was a thrilling match towards the finish, and the team is to be congratulated upon their good fielding and all round play.

Special mention should be made of the batsmen mentioned above, the fine fielding of G. P. Lindsay, and of the perfect bowling of Skeels and Biddle—both these players retained a very good length throughout the game and it was pure bad luck that they did not meet with the success they deserved—Bart's. found it very difficult to score freely against these two bowlers.

ST. BART'S.

B. G. Melle, b Shaw	92
S. Orchard, b Skeels	19
A. E. Parkes, c Whitcombe, b Woolridge	4
P. C. Collins, c and b Biddle	13
C. Bracewell, b Woolridge	10
H. D. McCall, c Lindsay, b Shaw	18
M. G. Thomson, run out	3
H. G. Handley, c Lindsay, b Shaw	4
J. Parrish, c Helder, b Shaw	4
C. Shaw, b Biddle	0
H. K. Molock, not out	0
Extras...	20
	187

Biddle,	2 wickets for 46	Shaw,	4 wickets for 16
Skeels,	1 " " 31	Wharton,	0 " " 20
Woolridge,	2 " " 54		

GUY'S

G. P. Lindsay, c Bracewell, b McCall	0
G. D. Shaw, b Melle	55
E. Woolridge, c Parrish, b Melle	2
D. M. P. Whitcombe, b McCall	3
S. Rose, c Bracewell, b Melle	27
C. Biddle, retired hurt...	0
J. A. Wharton, b Melle	8
W. F. Payne, b Shaw	2
H. A. Harris, c McCall, b Parrish	50
L. B. Helder, c Handley, b Parkes	51
P. B. Skeels, not ont	14
Extras...	20
(For 9 wickets) ..	232

GUY'S v. BROMLEY.

Played at Honor Oak Park, Saturday, May 17th. Guy's must consider thenselves very fortunate in having been able to retain the services of their groundsman during the war. As the result of his efforts, the ground was in perfect condition, and the arrangements left nothing to be desired.

It was glorious weather, and winning the toss, Bromley decided to bat first on a very fast wicket. Skeels opened the bowling for Guy's at one end and Biddle at the other. Wickets commenced to fall fairly rapidly until Shaw partnered Tucker at the fourth wicket. He was lent to Bromley as the result of turning up a man short, and proved a very useful discovery. Shaw shows promise of developing into a high class batsman—he made the Guy's bowling look very simple. His innings included one 6 and seven 4's. Wharton eventually relieved Bernstein, and bowling with a good length immediately met with success. Bromley were finally out with the useful score of 205.

Guy's were left with 1¾ hours to get the necessary number of runs for victory. It looked as though the home side were in for a bad time, as Harris, Woolridge and Hilder were dismissed with the score at 19. Then D. M. P. Whitcombe joined Vincent Brown, and although both were very cautious to commence, they eventually mastered the bowling and runs came very rapidly, and within the hour 100 runs had been added between them. Whitcombe was finally caught when endeavouring to lift the ball to the boundary. This great partnership realised 150 runs, and it left Guy's 35 runs

to get in 20 minutes. Playing against the old enemy "time," made the game very exciting, as Rose was a little too cautious—he might have taken a few more risks. However, all went well, and Brown with two successive boundaries passed Bromley's score, and also completed his first century. Scores :--

BROMLEY.

P. E. Whiteoak-Cooper, b Skeels	6
A. G. Brown, c Whitcombe, b Biddle	0
G. N. Le May, b Woolridge	19
B. H. Tucker, b Biddle	22
G. D. Shaw, lbw Wharton	49
H. P. Strawson, b Wharton	22
A. L. Mark, b Wharton	4
C. L. Gregory, b Wharton	21
A. E. Earnshaw, not out	33
L. I. Eames, c Whitcombe, b Bernstein	4
A. E. Brooks, b Hilder	4
Extras	21
	205

Wharton, 4 wickets for	33	Helder, 1 wicket for	8
Biddle, 2 " "	44	Woolridge, 1 " "	43
Skeels, 1 " "	25	Bernstein, 1 " "	31

GUY'S.

C. Vincent Brown, not out	101
H. A. Harris, b Tucker	0
E. Woolridge, c and b Tucker	0
L. B. Helder, lbw, b Tucker	1
D. M. P. Whitcombe, c and b Tucker	78
S. Rose, not out	19
Extras	12
(For 4 wickets) ...	211

G. P. Lindsay, J. A. Wharton, H. L. Bernstein, C. Biddle, P. B. Skeels did not bat.

Papers by Guy's Men.

J. A. Ryle, M.B., B.S., M.R.C.P. : Mild bacillery dysentery ; clinical investigation and diagnosis.—*Lancet*, May 31st, 1919.

H. C. Cameron, M.D., F.R.C.P.: (1) Section from a case of tuberculous meningitis of the spinal cord simulating anterior poliomyelitis. (2) Case of primary atrophic muscular dystrophy (amyotonia congenita of Oppenheim) --*Proc. R.S.M.*, April-May, 1919, *Sect. Dis. of Child*, 23. Discussion on the ætiology, prevention and non-operative treatment of adenoids. *Ibid.*, Mr. J. H. Badcock, 40; Dr. H. C. Cameron, 45, 52.

E. I. Spriggs, M.D., F.R.C.P.: The examination of the vermiform appendix by X-Rays.—*Ibid.*, *Sect. of Electro Therapeut.*, 9.

A. F. Hurst, M.D., F.R.C.P. and J. L. M. Symns, M.D.: The hysterical element in organic disease and injury of the central nervous system,—*Ibid.*, *Sect. of Neurology*, 21.

Major Philip Turner and another : Notes on the treatment of wounds infected with bacillus pyocyaneus.—*Journ., R.A.M.C.*, May, 1919.

Capt. H. W. Barber, M.D., M.R.C.P.: Pyodermia of parasitic origin.—*Ibid.*

W. B. Secretan, M.B., F.R.C.S.: Voluntary hospitals. —*B.M.J.*, May 31st, 1919.

Col. Charters J. Symonds, C.B., M.S., F.R.C.S.: Treatment of bone sinuses by solid metal drains.—*Lancet*, June 7th, 1919.

P. P. Cole, M.B., B.Ch., F.R.C.S.: Fistula of the parotid in war wounds of the face and jaws.—*Ibid.*

Guy's Hospital Lawn Tennis Club.

A general meeting was held in the Anatomy Theatre, on May 22nd, 1919, Dr. Fawcett in the chair.

The office of President of the Lawn Tennis Club being vacant, owing to the retirement of Sir Arbuthnot Lane, Dr. Fawcett, was proposed and unanimously elected president.

Mr. Mollison was unanimously elected vice-president.

The Chairman pointed out that the Lawn Tennis Club had been in abeyance since 1914—that the minute-book had been lost—the last Secretary, he regretted to say, had been killed in the war—that they were gathered together to reconstitute the Club as well as they could on the old lines.

Officers were then elected :—

Committee.—Messrs. Tolton, Groves (representing senior years), B. L. Laver (third year), G. D. Shaw (second year), Wooldridge (first year), P. Krige (Dental School).

Hon. Secretary.—Mr. R. J. Hodgkinson.

It was decided that no captain should be elected for the present, but that one of the "six" representing the hospital should be elected by a special general meeting at a later date.

To assist the Committee in selecting a team, it was decided to hold a Tournament forthwith, so that all likely men should have their chance.

The question of running Second Team fixtures (other than Inter-hospital Junior Cup) was deferred till after the Tournament.

In conclusion, the Chairman said how pleased he was to do anything he could to encourage sports in the hospital. Farther, he felt that they could not re-start the Lawn Tennis Club without thinking of all the gallant men from their midst who had fallen in the war. He was sure that it would be the unanimous wish that their debt to these should not go unacknowledged. He proposed that this small tribute to their great sacrifice should be recorded in the minutes. This was unanimously adopted.

The meeting was well attended, and showed that there are numbers of men interested in the game. In spite of this very late start, it is hoped that a number of matches will be arranged. A fixture list cannot be settled until the Inter-Hospital Cup fixtures have been settled.

Reviews, etc.

Materia Medica and Therapeutics. G. J. Mitchell Bruce and Walter J. Dilling. (Carrell & Co.) 9s. net. Eleventh Edition.

The eleventh edition of this extremely useful and compact little book deserves a continuance of the popularity among medical students which its previous editions achieved. The present edition is essentially a War-time one, for it not only contains the War amendments to Pharmacopœa of July, 1917 and March, 1918, but also those branches of therapeutics which have been so extensively developed during the War are considerably amplified, such for example as Electrical Treatment, Massage, and Exercises, Surgical Dressings and antiseptics. The book fits conveniently into the pocket. As a text-book of Materia Medica it is well arranged and has a very considerable range of usefulness for Students.

The Intensive Treatment of Syphilis and Locomotor Ataxia by Aachen Methods. By Reginald Hayes, M.R.C.S. Third Edition. (Messrs. Baillière, Tindall & Cox.)

The third edition of Mr. Hayes' little book differs but little from the earlier ones. The author's claims for mercurial inunction, properly carried out by trained rubbers, are not, we think, in any way exaggerated, but the method seems to us hardly applicable as a routine treatment in a large venereal clinic. At the same time, for special cases, particularly those in which the central nervous system is involved, the inunction might well be more widely employed, the chief difficulties to be contended with, of course, being the scarcity of trained rubbers, on whose skill and conscientiousness so much depends, and the expense entailed.

The internal administration of sulphur, which constitutes part of the Aachen method, might also be practised oftener, even if mercury be given by other means than inunction, for there is evidence to show that sulphur aids the action of mercury and lessens the liability to intolerance of the drug.

The book is clearly written, and several cases, chiefly of syphilis of the nervous system, are described as illustrating the efficacy of the Aachen method.

Transactions and Seventh Annual Report of the London Dermatological Society. (Messrs. John Bale. Sons & Danielsson, Ltd.) 1919.

This volume contains reports of cases shown at the meetings of the Society during the Session 1917—18, together with seven papers on dermatological subjects by certain of its members, and an opening address by Dr. Leonard Williams on "The Real Dermatology."

As might have been anticipated, Dr. Williams has little use for the dermatologist or the profession he practises; in fact, he condemns modern dermatology as a "revel in irrelevant terminology," and he accuses dermatologists of an excess of mutual admiration, an accusation, we think, that will cause them no little surprise. For him the "Real Dermatology" like the "Real Neurasthenia," is an affair of the ductless glands, and he asks that the effect of small doses of these be tested in diseases of the skin.

While admitting that an intimate relationship exists between the health of the skin and its appendages and the activities of these glands, it must be confessed that the oral administration of thyroid and other gland substances in varying amounts has, on the whole, proved disappointing in dermatology. Moreover, we do not understand the primary conditions which lead to deficiency or excess of the secretions of the endocrine glands, be the disturbance congenital or acquired. That bacterial toxins may affect the thyroid, suprarenals, etc., is known, and the views of Sir Arbuthnot Lane on this subject have obtained considerable confirmation; in any case it is difficult to imagine how disorders of gland secretion can be a primary condition, so that, granting that such disorders may produce a morbid state of the skin, it is evident that we must look farther for the secret of the "Real Dermatology." At the same time Dr. Williams has some sound remarks to make concerning the invasion of the skin by bacteria; with him we hold that it is not enough to know that this or that disease is associated with this or that bacterium, we must inquire what constitutes the underlying morbid state which enables these organisms to flourish.

Among other papers reference may be made to one by Dr. R. Prosser White on "Ulcers of the Leg (miscalled Varicose)." The author brings forward evidence to show that the deep intractable ulcers, so frequently met with in women, are due not to varicose veins, but to a previous phlegmasia, or streptococcal lymphangitis. The only illustration in the book, that of a case of keratosis folliculosis, might as well have been omitted, for it conveys no impression to the eye of this or any other disease.

As regards the reports and discussions on cases shown at the meetings of the Society, one is struck by the widely different diagnoses suggested by members for what would appear to be obvious conditions. For example, in a case shown by Dr. Knowsley Sibley as a probable one of dermatitis artefacta, in which the lesions were those of an acute folliculitis, the diagnosis of pityriasis versicolor was suggested by one member!

Mr. Siggs wishes to thank all the "Niggers" who so kindly subscribed towards a silver inkpot for him last Christmas.

Birth.

DENNEHY.—On Feb. 13th, 1919, at Aston Grays Nursing Home, Bournemouth, to Daisy, wife of W. J. Dennehy, a son, prematurely (John Hugh Latcham).

Marriages.

SOMERVILLE—BROWNING.—On Jan. 7th, 1919, Miss L. C. Browning to Stanley Somerville, Esq., Batu Gazah, F.M.S.

TAYLOR—MARRIOTT.—On March 4th, 1919, Miss O. T. Marriott to W. B. Taylor, Esq., Elphil Estate, Sungei Siput, Perak, F.M.S.

Death.

DENNEHY.—On Feb. 23rd, 1919, of pneumonia following influenza, Daisy Annie Dennehy, née Latcham, the very dearly loved friend and partner of Margaret Fletcher, aged 34. R.I.P.

ED.—G. B D.

GUY'S HOSPITAL GAZETTE.

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Passim.

OLD CLINICAL AND NEW.

We do not know many definite facts regarding the new Hospital building schemes that are being considered at the present time. We are able to state, however, that during the next few years several new wards will be built on the top of Hunt's House, while the site at present occupied by the ruins of John Ward will be taken up by an extra wing of the Nurses' Home.

Miriam Ward is to be left standing temporarily to be used as a ward for babies until the new wards are completed.

Clinical has many associations and traditions which are dear to the hearts of all Guy's men, the recent demolition of John Ward must have been witnessed therefore with universal regret. Clinical is not, as is supposed by many, quite the oldest part of Guy's Hospital. It was built in 1744 for the accommodation of twenty confirmed lunatics in accordance with the directions contained in Guy's Will six years after the original building, Guy's House, now occupied by the Surgical Wards and Theatres. It remained a House for lunatics until in 1859 the Governors of the Hospital arranged for the reception of its inmates elsewhere, and the building was converted into two wards for general hospital purposes.

The Guy's Hospital Reports of 1844 contain an account of the original Clinical wards which were then Job and Lydia, and were termed Clinical as being set aside from the rest of the general wards as being expressly devoted to the purposes of bed-side instruction and observation. Between the two wards was a room for the meeting of physician and pupils, and the registering of cases, while at the back of this room was a "clinical laboratory for the examination of morbid secretions, blood, etc." The reports were made by four clinical clerks who were selected from the "more advanced pupils who had distinguished themselves by their ability and diligence in reporting in the general wards." These reports formed the subject of conversation between the physician and the pupils at the bedside, and of a formal Clinical Lecture delivered weekly.

Miriam and John became the Clinical wards immediately after their conversion from a Lunatic House to General Hospital wards. In 1915, on account of war exigences, the greatest and most cherished of our Hospital institutions had to be given up for the time being. Clinical no doubt will shortly become re-established, perhaps, to begin with, in certain of the present medical wards, but ultimately in the new buildings.

It is clear that the functions of Clinical, as described by Dr. Barlow in the Guy's Hospital Reports of 1844, and adhered to fairly closely right up to the time of the war, may have to undergo considerable alteration in the future.

Time has shown clearly that the spirit of investigation is the very life of medical progress, and wherever this spirit has flourished in a medical school so has that school prospered. The spirit of research must be cultivated in the future above all other things. Clinical of the future might well be devoted entirely, or almost entirely, to medical research rather than only to the diagnosis of difficult or acute cases.

THE most prominent fact borne out in the Annual Report for 1918 is that the Hospital, in the face of difficulties that appeared almost insuperable at the beginning of the year, has carried on its work without interruption in any department. It will be remembered not only that the Hospital began the year with a deficit of £13,000, but that throughout the greater part of the year a continuous depletion of staff was taking place, so that at one time it appeared that a considerable curtailment of the Hospital's services would become inevitable. The strain began to relax soon after the Armistice, and it now becomes possible to consider the schemes for reconstruction which should have started three or four years ago, but which have of necessity been held in abeyance during the war.

The ordinary expenditure during 1918 reached a total of over £110,000, the greatest annual expenditure in the history of the Hospital. This is of course accounted for by the great rise in cost; for the number of patients treated has decreased by more than 10 per cent. since 1914.

There is, however a balance of income over expenditure of about £2,000, a result that is due chiefly to a large amount received from legacies.

The financial position is, however, by no means free from anxiety, for the Hospital has practically no reserves, while the schemes and improvements which have long been planned call for immediate action to be taken.

IT may be of interest to summarise briefly the work that was carried out by Officers Section during the war. The Section was opened on November 3rd, 1914. The Governors first offered to erect a large canvas pavilion in the park for the treatment of wounded soldiers. The offer was rejected by the War Office, and it was then decided to devote Stephen Ward to the treatment of officers. In twenty-four hours the Works Department carried out the conversion of Stephen into an Officers Ward, and for over four years the Section was occupied by Naval and Military Officers, 1,199 having received treatment. The treatment was directed by the Hospital Staff and House Officers, and the whole expense was borne by the Hospital.

The great value of Officers Section has been borne out by letters expressing warm appreciation of the services rendered from both Naval and Military authorities.

WE would like to draw the attention of authorities to the disordered state of the notice boards in the colonnade. At the present moment the number of notices appearing is so large that many a man is turned away in despair. For ourselves, we believe that this state of affairs could be promptly and simply remedied if notifications of events occurring three or more months ago were removed. It is our intention in this Journal to publish a fortnightly summary of the meetings of various societies and other events of interest. In order to render this summary as complete and

accurate as possible, the secretaries of various hospital organisations are invited to send notices to the librarian on the Tuesday preceding the date of publication of the GAZETTE.

WE feel sure that all our readers will join us in heartily congratulating Mr. W. J. Curry on the admirable pluck which he displayed upon the occasion of an attempted robbery that took place in the Counting House on Friday, June 20.

The details of this outrage are so well known that only a scant reference is necessary. Suffice it to say that the two robbers who, it appears, had been waiting their opportunity for some time in the Court Room, suddenly appeared masked in Mr. Curry's office and presented each a pistol at his head. Mr. Curry promptly closed with them, and in a very short space of time hustled them both out of the Counting House, having succeeded en route in acquiring both masks.

The robbers unfortunately were armed with iron bars as well as pistols, and Mr. Curry sustained some severe cuts about the head and face. Nothing was taken from the Counting House, but it is none the less regrettable that both thieves succeeded in getting clear away, and have not yet been caught. We wish Mr. Curry the speediest recovery from his wounds.

OUR heartiest congratulations to Mr. R. C. B. Ledlie, who has been awarded the Treasurer's Gold Medal for Surgery, and to Mr. J. V. C. Braithwaite, who has been awarded the Treasurer's Gold Medal for Clinical Medicine.

OUR apologies to Dr. Herbert French for a mistake in our last issue. The honour conferred upon him was the C.B.E., not the C.B., as announced in the GAZETTE.

Guy's Hospital.

Applications for the following appointments should be sent to the Treasurer at the Superintendent's Office not later than July 5th:—

HOSPITAL AND MEDICAL SCHOOL.

I.

4 Medical Registrars and Tutors.
4 Surgical " "
4 Medical Assistants.
4 Surgical "

Gynæcological Assistant and Registrar.
Midwifery Assistant and Registrar (whole time).
Resident Surgical Officer (whole time).

II.

Officer in Tuberculosis Department.
Assistant in Neurological Department.
" " Dermatological and V.D. Department.
" " Children's Department.
Junior Surgical Radiographer.
Assistant in Electrical and Actinotherapeutic Depart.
2 Assistants in Throat Department.
Orthopædic Registrar with Charge of Orthopædic Workshop.
Assistant in Genito-Urinary and V.D. Department.
2 Assistants in Ophthalmological Department.

III.

3 Demonstrators of Physiology.
2 " " Clinical Chemistry.
2 " " Pathology. Gull Student. Douglas Demonstrator.
2 " " Bacteriology (one whole time).
Demonstrator of Pharmacology.
Hilda and Ronald Poulton Fellow.
3 Demonstrators of Anatomy.
Demonstrator of Morbid Histology.
" Public Health.
" Physics.
2 Demonstrators of Biology (one whole-time).
3 " Chemistry (two whole-time).

In order to promote the linking-up of the different Departments of the Hospital and School, men will be expected as a general rule to hold two of these posts concurrently.

The greatest freedom of choice will be allowed conditionally to the 8 Registrarships and certain essential Demonstratorships in the Hospital and Medical School being filled up.

June 24th, 1919.

Papers by Guy's Men.

Sir Geo. H. Savage, M.D., F.R.C.P.: Post-graduate lecture on mental disorders associated with old age.—*Lancet*, June 14th, 1919.

—.: A meatless dietary in epilepsy.—*Ibid.*

N. I. Spriggs, M.D., F.R.C.S.: Infective catarrh—so-called "colds."—*B.M.J.*, June 14th, 1919.

Lt.-Col. A. H. Carter, M.D., F.R.C.P.: An analysis of symptoms in cerebro-spinal fever; based on 100 cases of epidemic meningitis, chiefly due to meningococcus.—*Lancet*, June 21st, 1919.

Prof. E. H. Starling, C.M.G., M.D., F.R.S.: The Oliver Sharpey lectures on the feeding of nations; a study of applied physiology.—*B.M.J.*, June 21st, 1919.

P. P. Cole, M.B., Ch.B., F.R.C.S.: Radical cure of femoral hernia, by inguinal route.—*Ibid.*

The Late Symptoms of Gas Poisoning and their Treatment.

CLINICAL LECTURE BY DR. HUNT.

GENTLEMEN,—I am taking the late effects of gas-poisoning as the subject of my lecture to-day for two reasons: firstly, because the effects persist for so long after the patient has been "gassed" (it may be for months, or even years), that many of you will be called upon to treat them; and secondly, because practically nothing has appeared in the medical press which gives any indication of the methods of doing so.

Before dealing with the late effects of gas-poisoning I must say a word about the acute stage. The gasses most frequently used by the Germans belong to two groups: the suffocative and vesicant. Chlorine, phosgene, and chloropicrin were the commonest examples of the suffocative group; the only common vesicant was dichlorethyl sulphide, usually known as mustard gas, or Yperite. The suffocative gasses act primarily on the lung epithelium, and produce acute œdema of the lungs and thrombosis of the lung capillaries, but have little effect on the bronchi. The vesicant gas, on the other hand, acts primarily on the upper air passages and bronchi and produces an acute bronchitis which, in the more serious cases, goes on to broncho-pneumonia. As I shall show you later, we know comparatively little of the final condition of the lungs of patients who survive, but, whatever the gas used, so much of the lung is thrown out of action during the acute stage, that for a time the patient's blood is insufficiently aerated, and his tissues are insufficiently oxygenated. This want of oxygen produces widespread changes in various parts of the body, and it is believed by some that the damage so caused to the various tissues, especially the brain tissue, is responsible for the disability that follows.

I am speaking of the late effects of gas-poisoning, and I am using the word "late" in a very wide sense to indicate all those symptoms, which persist after the acute symptoms of lung irritation are over. The acute symptoms may last from a few days to two months or longer, and thus the late effects may not become manifest, until some time has elapsed after the man has been "gassed." The duration of the late symptoms varies very much; some patients recover from them in a week or two; others suffer from a varying degree of disability for years, and these are the patients whom you will have to treat or assess at the pensions boards.

Let us now consider the symptoms that occur in such cases. I can dismiss very briefly the results of the burns and the eye lesions that follow mustard gas poisoning. By now the burns are all healed, and the only condition you will meet with is the contraction of the tissues that occasionally results. The conjunctivitis, too, that is caused by mustard gas rarely leaves any organic disease of the eye that persists for any length of time. In the large majority of cases the patient will tell you that what troubles him most is inability to stand any hard muscular exertion, and it will be your task to determine what degree of disability he has, and to prescribe appropriate treatment. I will now describe to you in more detail the symptoms that cause this. They are as follows:—

1. DYSPNOEA.

(a) *At rest.*—In severe cases this may be obvious when the patient is at rest; on counting his respiration rate you may find that it is faster than normal, and possibly you may notice that his respiration is shallower than normal. Haldane and Meakins have laid great stress (I think too much stress) on this reduction in the depth of respiration. I have seen it occasionally, but my experience has been that it is not a very common feature of the respiration. Be that as it may, patients will sometimes tell you that they find it difficult to breathe deeply, and that an attempt to do so causes pain and makes them cough. I shall return to this point later.

(b) *On exertion.*—This is a very common symptom. It varies very much in degree; some patients are short of breath after walking up a single flight of twenty stairs; other patients can do this without any difficulty, but experience distress if they walk up two flights; others, again, only become short of breath after walking up four or five flights. Associated with this dyspnœa is tachycardia, and the effect of exercise on the pulse rate is so important that I must describe it in some detail. If a healthy, well-trained man takes exercise, you know that his pulse rate rises, and then

after an interval returns to the pre-exercise rate. I have made a good many observations on normal subjects, and find that if a well-trained man walks up and down a flight of 20 stairs (with a tread of 6 inches) six times in 2 minutes, his pulse rate after the exercise rises, and at the end of the exercise returns to its original rate (*i.e.*, the rate counted at rest before the exercise) within a minute; after any easier exercise the return of pulse rate occurs after a shorter interval. "Gassed" patients show important differences from the normal in this respect; in them the pulse returns after exercise to its original rate much more slowly than normal; for example, I saw a patient three months after he had been "gassed," and made him walk up and down three flights of stairs in one minute; his pulse was 104 before he started, and it did not return to this rate until five minutes after the exercise was over. The effect of exercise on a patient's breathing and pulse rate affords a very good indication of the severity of the case. If you find out what amount of muscular exertion causes undue dyspnœa and an abnormally slow return of pulse rate, you will be in a position to form a fair estimate of his capacity for muscular work. Further, you will be able to judge of the effect of your treatment. If you give him the same exercise as a test before and after treatment, and find that after treatment the exercise causes less dyspnœa and that his pulse rate returns to its original rate more quickly, you will know that your patient has improved.

(c) *At night.*—Many patients are subject to attacks of dyspnœa at night, and these attacks are of two types. The first is really the result of coughing; during sleep the patient may take an unusually deep breath; this deep breath, as I have pointed out already, makes him cough; the coughing causes him to take more deep breaths, which in their turn cause more coughing, so that a vicious circle is established, resulting in a violent paroxysm of coughing, which exhausts the patient, and makes him gasp for breath. This type usually follows poisoning by mustard gas. In the second type the attacks are not associated with coughing. During an attack the patient sits up in bed, his respiration is shallow and rapid, but not difficult, thus differing from the respiration in ordinary asthma, but resembling the dyspnœa seen in cases of uræmia. He may be slightly cyanosed, but more commonly his colour remains natural, and he appears anxious rather than acutely ill. These attacks last from five minutes to an hour, rarely for longer. During an attack the condition of the pulse is very variable: in some cases it is slow and full, in others it is rapid and almost impalpable. The attacks may occur every night, or may be separated by long intervals, and I have known them persist for eighteen months after the patient was "gassed." These attacks usually follow poisoning by one of the suffocative gasses.

2. PAIN.

This is of two kinds. It may be situated behind the sternum and on both sides of it, and is much worse when the patient coughs or takes a deep breath; it is increased by exercise, as this causes the respiration to become deeper. In other cases the pain is chiefly precordial; some patients may complain of it at rest, but most patients only get it on exertion. After an amount of exercise that tries the patient severely, the pain may be very intense, and may even simulate angina pectoris.

3. COUGH.

Gas-poisoning, particularly by mustard gas, may give rise to a chronic bronchitis, and this presents hardly any features that distinguish it from bronchitis due to other causes. There is, however, one point to remember about it: the sputum not infrequently contains streaks of blood. Any patient with hæmoptysis requires careful investigation, for I am quite sure that gas-poisoning may light up an old tubercular focus, but remember that hæmoptysis may occur from ulcers in the bronchi caused by mustard gas.

Many patients, however, complain of cough when they have no signs of bronchitis and little or no expectoration; in these cases the cough has a dry ringing character, and is due to irritability of the upper air passages. I have already pointed out to you how the slight stimulus of an unusually deep breath causes coughing in some patients.

4. NERVOUS SYMPTOMS.

Many "gassed" patients are neurotic, and this is shown in various ways. Some patients are depressed mentally, and it is very common for them to have the idea that they are never going to recover completely. This idea of a permanent incapacity often renders them unwilling to make a real effort to increase their powers of endurance. In other cases symptoms

are referred to particular parts of the body. Headache is extremely common; it is usually frontal, occasionally occipital, rarely universal; it is often associated with giddiness, particularly on exertion. Functional disorders (a) of the eyes, (b) of the larynx, (c) of the digestive system may be present.

(a.) Photophobia is always present with the conjunctivitis of the acute stage, and may persist for a long time after all inflammation has ceased.

(b.) Functional aphonia is common even when laryngeal examination reveals nothing abnormal; it occasionally recurs quite suddenly after having been absent for weeks. (It is only occasionally that the laryngitis of the acute stage becomes chronic; when it does it is very intractable.)

(c.) Vomiting very often starts soon after the patient is "gassed," and may persist for a long time during convalescence. Very occasionally this is due to ulceration in the stomach, but in the very large majority of cases it is functional in origin as is shown by the following facts :—

1. Hæmorrhage is very rare.

2. X-ray examination shows that the stomach is normal in size, and that its motility is normal.

3. The stomach contents after a test meal show no increase in hydrochloric acid. (Occasionally the hydrochloric acid is diminished.)

4. Vomiting, after being absent for several weeks, may start again as the result of any mental worry.

5. Suggestion in various forms will often cure it.

So much then for the symptoms. We now come to the pathology, and here we are not on very sure ground. In a certain number of cases chronic bronchitis is the out-standing feature, and the pathology here is similar to that of chronic bronchitis from other causes, and need not detain us. The difficulty arises, however, in patients who are apparently perfectly well, and yet are incapable of standing exertion. Briefly, the problem I met with in France in 1916—and you will meet with the same problem in dealing with these patients—was this: a patient presented himself, looking perfectly fit and free from any sign of disease on ordinary clinical examination, and yet if he walked a few hundred yards, he returned very short of breath, obviously very exhausted, and with a pulse rate which remained abnormally rapid for a long time. (My patients at this time were all suffering from poisoning by suffocative gasses. I believe Dr. H. W. Barber was the first to describe the same symptoms as the result of "mustard gas" poisoning.) Now these patients had all had a severe lung lesion, and therefore it was possible that they might have some fibrosis of the lung and emphysema, sufficient to cause symptoms, but not to be diagnosed by physical examination. One or two post-mortem examinations have been made some weeks after gas-poisoning, and the histological appearance of the lungs lends some support to this view, but patients who survive the acute stage rarely die, so that we know very little about the morbid anatomy of the condition. Radiographers have occasionally reported cases showing some fibrosis, but here again the evidence is not sufficient to be conclusive. There is, however, one feature that throws some light on the condition, and its discovery afforded the basis for one of the methods of treatment, and that is the fact that polycythæmia occurs in some of these patients. When I began investigations on this subject, I had the good fortune to be working with Dr. C. Price Jones, an old Guy's man, and an expert hæmatologist. He examined a large number of my patients, and found that in many cases the red cell count was increased, sometimes up to seven millions, with an increase in the hæmoglobin percentage. This polycythæmia was almost confined to patients who had the dyspnœa at night, which resembled uræmia. Now I have already pointed out to you that during the acute stage of their illness "gassed" patients suffer from lack of oxygen, and it seemed possible that the polycythæmia was a compensatory reaction on the part of the body against a persistent condition of oxygen want. A comparison between "gassed" patients and that of dwellers at high altitudes strongly supports this suggestion, for the latter have polycythæmia, and suffer from dyspnœa and tachycardia on exertion, nocturnal attacks of breathlessness and occasionally from some mental alteration, features which are common in "gassed" patients; in both conditions, too, acidosis is present. It has been definitely shown that the condition found in dwellers at high altitudes is the result of an insufficient supply of oxygen, and that the symptoms and polycythæmia disappear on a return to the sea-level where the oxygen tension is greater. Mr. J. Barcroft, of

Cambridge, suggested to me that a similar beneficial effect might be produced in "gassed" patients by keeping them in an atmosphere rich in oxygen, and so raising the tension of oxygen in their alveolar air. This brings me to the question of treatment.

TREATMENT.

The symptoms you will be called upon to treat fall into three groups—1. Inability to stand exertion; 2. Chronic bronchitis; and 3. Functional disturbances.

1. *Inability to stand exertion.*—There are only two methods of treating this—(a) continuous inhalation of oxygen, and (b) graduated exercises, and the best results are obtained by a combination of both methods.

(a.) The best way of giving oxygen is to keep the patient in a chamber, in which the atmosphere contains 45 per cent. to 50 per cent. oxygen, but the treatment can also be given by using the Haldane apparatus. The difficulty in the latter method is that some patients find prolonged wearing of the mouthpiece very irksome, but as chambers for giving oxygen are not often available, you will probably have to rely on the Haldane apparatus. The results of oxygen treatment are extremely satisfactory, and I can best illustrate them by describing the first patient I treated in this way. He was a bricklayer's labourer, aged 47, and was "gassed" in a munition factory about a year before I saw him. He recovered from the acute symptoms after a few days, but since that time had been short of breath on exertion and had had attacks of dyspnœa at night. These attacks occurred every night, sometimes twice in one night, and might last as long as three hours, with the result that he had not had a single night of undisturbed sleep for twelve months. Previous to being "gassed" he had been a perfectly healthy man and capable of doing very heavy work. On examination he looked perfectly well, his arteries were not thickened, and nothing abnormal was found in his chest or abdomen; his urine was normal. His red cell count, however, was 6·1 million. His response to exercise was tested by making him walk up and down stairs for four minutes; after this test he was very short of breath and his pulse did not return to its original rate (the rate before exercise) for 32 minutes. He was treated in the physiological laboratory at Cambridge by being kept in a chamber of about 800 cubic feet capacity, which was made of glass and iron, and which contained an atmosphere of about 45 per cent. oxygen. The air of the chamber was kept circulating by means of electric fans, and was passed over soda-lime and calcium chloride to remove carbon dioxide and excess of water vapour. The patient remained in the chamber for the greater part of four days and nights. (In treating subsequent patients the routine treatment was as follows: the patient entered the chamber at four o'clock in the afternoon and remained there until nine o'clock the next morning, spending the rest of the day in the ordinary air. He did this on five successive nights.) The effect of treatment was excellent. He slept on an average eight hours every night, and did not have a single attack of dyspnœa. His response to exercise improved considerably; he was given the same test exercise after treatment, and said that he found it much less exhausting. His statement was born out by objective signs, for his dyspnœa was obviously much less, and his pulse returned to its original rate six minutes after the exercise, whereas before treatment it did not return for 32 minutes. His red cell count fell to 5·2 million. The improvement persisted in every way for a month afterwards, when he unfortunately got "gassed" again, and his symptoms returned, although not so severely as before treatment.

I have treated about thirty patients in this way and over 90 per cent. have improved; in the majority of the cases I have traced, the improvement, contrary to my expectation, has persisted in every way, although in some cases there has been a disappointing relapse. One patient who relapsed afforded me the chance of testing whether the effect of oxygen treatment was due merely to suggestion. He was a patient who suffered very much from dyspnœa at night; he was treated with oxygen and his attacks stopped for a time, but recurred after about a fortnight. He was put in the chamber again; for the first three nights he was kept, without his knowledge, in an atmosphere of ordinary air; he had an attack of dyspnœa every night. On the fourth night and succeeding nights he was kept in oxygen in the usual way and his attacks did not occur. I have not time to discuss in full the other arguments against the theory that the improvement resulting from oxygen treatment is due to suggestion, but briefly they are the following:—

1. It is very unlikely that suggestion would cause such marked alterations in the return of

pulse rate after exercise, or that it would diminish dyspnœa. (That the dyspnœa was actually less was shown in the later cases by means of actual measurements.)

2. Patients suffering from dyspnœa, on exertion, owing to organic heart disease, "effort syndrome" or "D.A.H." and chronic nephritis, do not improve with oxygen treatment. If the improvement in "gassed" patients was due to suggestion, improvement would be expected at least in some other cases.

3. Patients suffering from ordinary asthma, a condition in which there is at any rate some neurotic element, and which therefore might be expected to benefit from treatment by suggestion, do not improve to any appreciable extent.

4. It is inconceivable that polycythæmia could be affected by suggestion.

(b) Graduated exercises on the lines practised at the military heart hospitals have deen extensively used, and in France this was the only method of treatment at my disposal; many patients recover completely with this treatment only. It consists in "training" patients by gradually increasing the amount of exercise they take, and this may be done by making them march for increasing distances, by giving them a graduated system of physical drill, or by making them play games. at first games which involve little muscular exertion, and later more vigorous games. I feel very strongly that whatever system is used the patient should be kept under medical supervision, for I have frequently seen men become worse as the result of doing too much, or fail to improve as the result of not doing enough. It may be true that patients suffering from effort syndrome from causes other than gas-poisoning do not damage themselves by over exertion, but it is certainly not true of "gassed" patients. It is impossible to lay down hard and fast rules as to the amount of exercise that should be taken; if the patient does not appear distressed or unduly short of breath, and if his pulse rate has fallen below 100 two minutes after the cessation of the exercise, it is generally safe to assume that the amount of exercise taken has not been too much for him; signs of distress, abnormal dyspnœa and persistent tachycardia should warn you that you are increasing the amount of exercise too rapidly, and that unless you diminish it the patient will become worse While I am on the subject of exercise let me say a word about absolute rest; don't keep your patient in bed longer than is absolutely necessary; in chronic cases of gas-poisoning if you find a patient free from any sign of organic disease, with a normal temperature and well nourished, don't keep him in bed simply because his pulse is fast; absolute rest will only make his muscles flabby, accentuate any functional symptoms that may be present, and will not reduce his pulse rate. Get your patient into a chair which he can wheel about himself if this is the utmost amount of exertion he can stand. The only exception to this rule is afforded by severe cases of functional vomiting; it is sometimes necessary to keep such patients in bed for a short time.

You will not find drug treatment of much value, but general tonics and bromide are occasionally useful. I have tried prolonged treatment with full doses of digitalis, but have never seen it relieve the symptoms or reduce the tachycardia.

2. *Chronic bronchitis.*—This is the predominant feature in a small number of patients, and the treatment does not differ from that of chronic bronchitis due to other causes.

3. *Functional disturbances.*—I have already pointed out to you that these are very various. It is most important to convince the patient that he is going to be completely cured, for the chronic depression from which many of these patients suffer is a serious obstacle to their recovery. Patients with photophobia without organic eye disease are very inclined to persist in the use of darkened glasses long after their use is unnecessary; they must be encouraged to give them up, and if they start doing so indoors, where the light is less strong than outside, they can soon be persuaded to dispense with them altogether. Functional aphonia must be treated by persuasion and breathing exercises, or by the application of a strong faradic current to the larynx. If these measures fail, give the patient an anæsthetic, preferably ether in a Clover; get him as excited as possible during the second stage, and if he comes round still shouting your success is assured. Functional vomiting is sometimes very obstinate; it sometimes yields to treatment by suggestion; in other cases washing out the stomach will effect a cure. In very severe cases it may be necessary to keep the patient in bed for a few days on a milk diet.

I have only been able to describe briefly the late effects of gas-poisoning, and to indicate the chief lines of treatment. In dealing with these patients you will find that the commonest complaint is inability to stand exertion, and your

examination will not be complete and your treatment will not be successful unless you find out by seeing them take exercise how much exertion they really can stand. It is only in this way that you will be able to assess their disability fairly, and prescribe for them the amount of exercise most suitable. If you do this, and can also treat them with oxygen, you will find the results of treatment extremely satisfactory, for you will cure the majority of your patients, and give considerable relief to the remainder.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—In the recent number of "Guy's Gazette" (*June 14th, 1919*) you publish an abstract of Mr. Thompson's clinical lecture on "Two Cases of Tuberculous Kidney." In his description of the first case, Mr. Thompson states that he considered the case a very suitable one for an operation, first recommended by me, in which I advised that the kidney and length of the ureter should be removed intact by two separate incisions to avoid the risk of a weakened abdominal wall by a long lumbo-ilio-inguinal incision ("Guy's Hospital Reports," 1910, vol. lxiv., p. 59).

Mr. Thompson then describes the operation which he performed in this particular case, from which he found so much inconvenience that he states that he will not perform the operation again. His operation, however, differs so essentially from mine that I venture to suggest that if in future he alters his proceeding so as to follow my description he will have little cause to complain of inconvenience. I therefore quote the words of my original description, which I have so far seen no reason to amend.

> "I have modified the operation in such a manner as to leave a broad bridge of muscle undivided. I first expose the kidney by the oblique lumbar incision, separating the peritoneum at the anterior part of the incision forwards. The renal vessels are then ligatured and divided and the upper part of the ureter separated downwards. After arresting any bleeding and providing for drainage, the kidney is tucked down into the lower part of the wound and the incision sewn up in layers. The patient is then turned into the dorsal position and an incision made in the iliac fossa parallel to Poupart's ligament, dividing the muscles in the line of the incision. The peritoneum is not opened, but is separated inwards from the iliac fossa, when the ureter is quickly identified as it crosses the iliac vessels and adherent to the peritoneum; a little separation upwards soon joins the line of separation from above and the kidney, lying loose in the retroperitoneal tissues, is delivered from the iliac incision. The lower part of the ureter is then separated and ligatured as before as low as possible in the pelvis and removed. In this manner two comparatively short incisions are made through the muscular wall of the abdomen, separated by a bridge of undivided tissues, and the ultimate result as regards the strength of the abdominal wall is much more satisfactory."

Mr. Thompson differs from me in doing the inguinal part of the operation before the lumbar. Whilst fully agreeing with him in the necessity of removal of the greater part of the ureter, I feel sure that it is not only better surgery, but an easier operation to first divide the renal vessels and then remove the kidney and ureter from the inguinal incision. I have now performed the operation in over twenty cases and have found no difficulty. In only one case have I had any trouble from tuberculous infection of the inguinal wound.—I am, sir, yours faithfully,

R. H. JOCELYN SWAN.

75, Wimpole Street, W.1.
June 19th, 1919.

Guy's War Memorial Fund.

	£	s.	d.
Brought forward ...	3,651	5	10
Hawes, W. A.	2	2	0
Warner, C.	2	2	0
Newland, W. D.	5	5	0
Audland, W. E.	2	2	0
Eyre, J. W. H.*	20	0	0
Victory, J.	5	5	0
Cuff, H.	2	2	0
Henry, C. John	3	3	0
Adams, Eustace H.	2	2	0
Nicholls, Frank J.	1	1	0
Baxter, C. W. W.	1	1	0
Hodgson, Stanley	3	3	0
Henry, Percy F.	5	5	0
Gowan, B. Campbell	1	1	0
Proceeds in respect of Dance (per W. H. Cellier)	70	6	6
Mandel, Leopold	2	2	0
Dean, L. T.	5	0	0
Cook, W. Warner	5	5	0
Fry, W. Kelsey†	5	5	0
Messenger, H. L.	5	5	0
Hunt, G. H.	21	0	0
James, Mrs. Joséphine‡	2	2	0
Welchman, F. E.	1	1	0
	£3,824	6	4

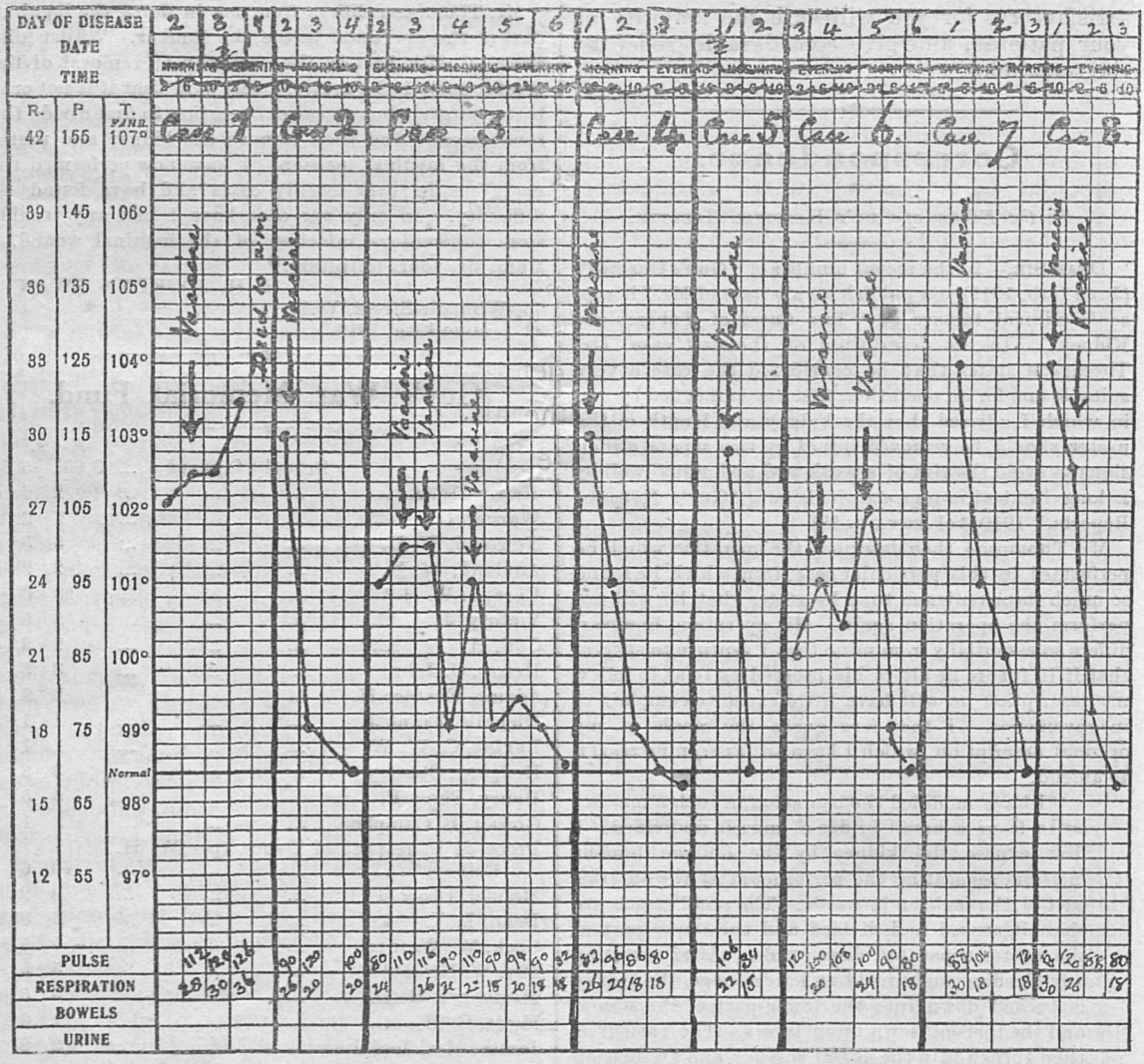
*Final instalment of total contribution of £50.

†Second instalment in respect of total contribution of £20.

‡First instalment in respect of total contribution of £10 10s.

Twenty Consecutive Cases of Influenza Treated by Mixed Vaccines.

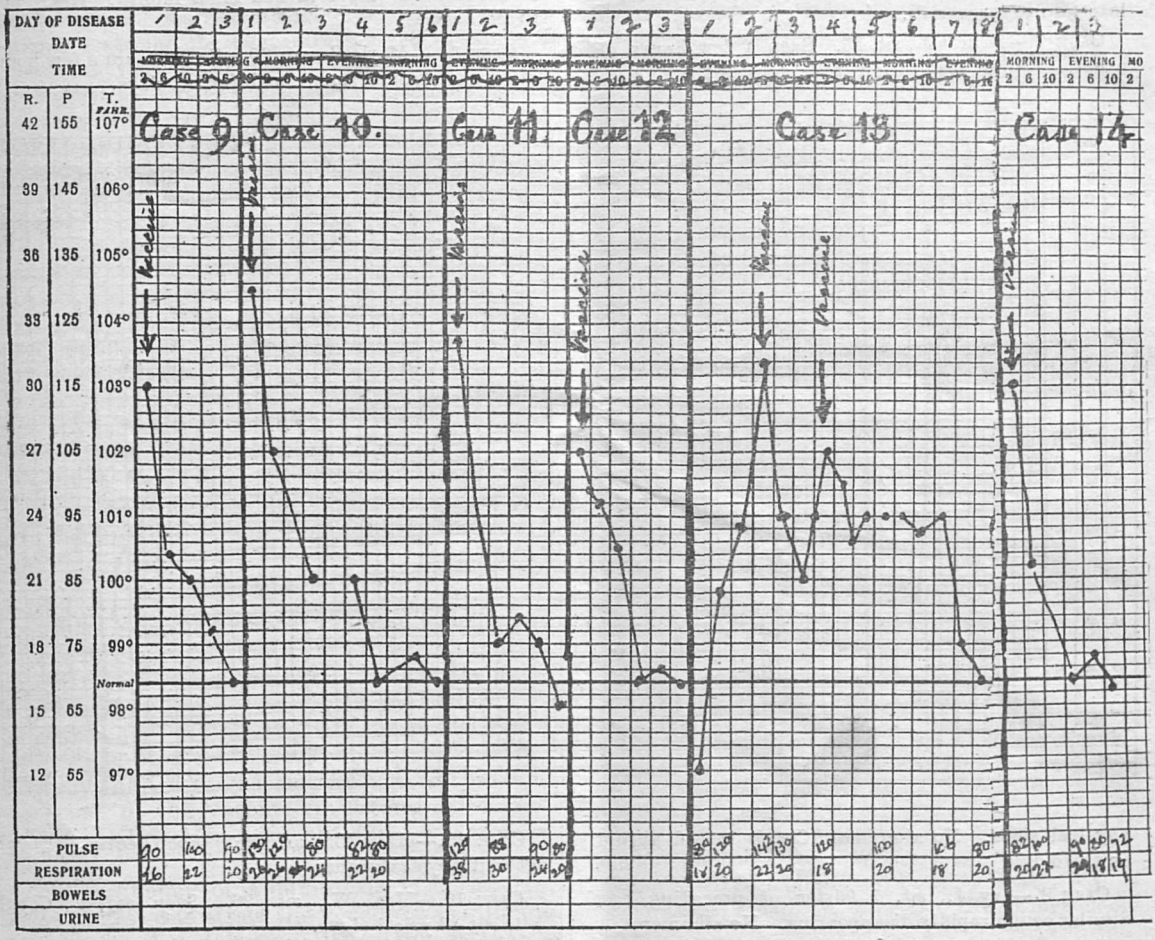
IN the "wave" of influenza in the months of February and March of this year I determined to give a fair trial to the vaccine treatment advocated by Dr. Wynne in his recent articles in the *Practitioner*. I had lost two cases that died of fulminant septic pneumonia within a few hours of the onset, and no treatment by drugs seemed to be of any use. I made up my mind to treat a consecutive series of cases with vaccines exclusively, but I can hardly claim to have done this, since in two or three cases (Nos. 17, 18 and 19), which were obviously in a desperate condition, I did not feel justified in withholding other measures that might possibly be useful. The remainder of the cases were treated with the vaccine exclusively, except that simple purgatives were given when necessary.



The appended charts and notes are necessarily very incomplete since all these cases were treated in their own houses, and no nurses were available to record temperatures, pulse rates, etc. I can only give the data of what I found when visiting the patients, and the

visits had to be reduced to a minimum owing to the severity of the epidemic.

The arrows on the charts show approximately the hour at which the injections were given, and an endeavour has been made to state the "day of the disease," but when whole families are suffering it is often hard to say at what hour a patient, who had been nursing others, actually sickened.



Besides the charts I append a few notes on each case, and subsequently summarize the results.

CASE 1.—Mrs. C., æt 46. Had been nursing a neighbour who had died of septic pneumonia within thirty-six hours of onset. Was first seen by me twenty-four hours after definite onset, and there were already fine crepitations in both lungs. Vaccine was injected, but by the next day both lungs were consolidated, the sputum swarming with mixed bacteria, and she died a few hours later.

CASE 2.—Winnie H., æt. 10. Seen about twenty-four hours after onset. Had had a cough since previous day, and this evening is said to have had "an attack," and gone blue in the face. Found with a remarkably croupy cough suggestive of diphtheria, but no albumen and knee-jerks lively; nothing in fauces. Moist sounds right base. Other cases of influenza in the house. Rapid improvement after one injection. Slight albuminuria on fourth day. Quite disappeared a week later. Kept longer in bed on this account.

CASE 3.—Mrs. S., æt. 31 (mother of Case 13, and sister of Case 12). Seen about twenty-four hours after definite onset, but had been nursing the other cases. Moist sounds in both lungs at first; cleared up in two days. Temperature normal after sixth day, but slow recovery of strength. No albumen. Heart sounds very weak.

CASE 4.—Mr. A., æt. 28. Much cough. Tenacious sputum free from colour. No physical signs. Rapid

recovery. Albumen present when first seen (before vaccine). None found subsequently.

CASE 5.—Mr. C., æt. 34. Seen on first day. Pulse remarkably rapid for early stage. Temperature normal when seen next morning. Not seen again, but reported as "quite well" on the fourth day.

CASE 6.—Mrs. R., æt. 40. Wife of Case 19, whom she had been nursing. Probably had been definitely ill for two days. Dry pleurisy left axilla. Slight transient albuminuria. Slow recovery after all fever had disappeared. Heart dilated slightly (now, four months later, quite recovered).

CASE 7.—Ernest J., æt. 15. Seen a few hours after onset. Rapid respiration and constant cough. No

physical signs. No albumen. Cough ceased abruptly on third day.

CASE 8.—Ivy J., æt. 7 (sister of preceding case). Similar cough rapidly disappearing. No albumen.

CASE 9.—Lily J., æt. 9 (sister of preceding). Trace of albumen on second visit. None four days later. Moist sounds both bases for three days. Two attacks of epistaxis. No albumen on fourth day.

CASE 10.—Mr. David C., æt. 34. Seen soon after onset. Bronchial catarrh of left base. History of previous pleurisy. Pulmonary signs remained some days after pyrexia had disappeared. Trace of albumen during first week. None found since.

CASE 11.—Mrs. I., æt. 41. Whole family have been aid up, and patient has been nursing them. Seen probably forty-eight hours after onset. Pleurodynia and crepitations at right base. These disappeared in about a week.

CASE 12.—Miss M., æt. 28. Troublesome cough for nearly a fortnight. No definite physical signs.

CASE 13.—Johnny S., æt. 4. In a state of collapse when first seen, and remained in a state of semi-stupor for first three days. Trace of albumen for first three days. Soft pulmonary systolic. No pulmonary signs. Slow recovery. Kept in bed for a month. Heart and urine normal.

CASE 14.—Marie B., æt. 20. Seen within a few hours of onset. Troublesome cough for two days.

CASE 15.—Mrs. E., æt. 26. Seen early. Cough without physical signs.

CASE 16.—Mrs. W., æt. 26. Seen early. Cough without physical signs.

CASE 17.—George W., æt. 27. First seen on sixth day of illness. Typical signs of lobar pneumonia of left base. Sputum rusty and swarming with mixed bacteria. Vaccine had little or no effect, the crisis occurring on the eighth day of the illness. Heart dilated when first seen. In this case other remedies were used after the crisis. Slight albuminuria during pyrexia. A month later heart no longer dilated and urine normal.

CASE 18.—Kathleen W., æt. 25 (sister of preceding). Had been ill at least two days before she took to her bed. Injection of vaccine appeared to affect the pyrexia, but

she had double pneumonia, patchy in distribution at first, but later confluent. Sputum crowded with mixed bacteria, chiefly streptococci. With the fall of temperature the lungs appeared to fill with fluid exudation, with which she was asphyxiated. Heart gave way completely, and there was much delirium from rhe first. Drugs used as well as the vaccine in this case.

CASE 19.—Thomas R., æt. 43, husband of Case 6. Seen within twelve hours of onset of symptoms. Found with fine crepitations at right base, and rusty sputum. Mixed bacteria. Marked albuminuria. After two injections of vaccine the temperature began to fall, but patient was cyanosed and in a state of stupor. Heart in good condition. Cyanosis and stupor gradually passed off, and by fourth day temperature was normal and no albuminuria. There was quiet delirium for two days. No alcoholic history. This passed off and the lung began to clear up satisfactorily. Tongue clean, eating well, supposed to be convalescent. Owing to pressure of work he was not seen again till the twelfth day, when he was reported to have suddenly become ill again. Now found to have a lobar consolidation at the other base, the right lung having cleared up completely. Another injection of vaccine affected the pyrexia, but the sputum took on a prune-juice character, and was remarkably tenacious. No albumen. Quantity of urine normal. No casts found. Heart rapid, but regular and not dilated. The death appeared to be asphyxial.

CASE 20.—Male, æt. 58. Rose with a headache. By noon a rigor and pyrexia. Injection given at once. At work again on third day. Troublesome cough for a month.

SUMMARY.

I think these cases show that the vaccine has an effect on the pyrexia in all but the latest stages, and that if given early, before the pulse rate begins to rise, often aborts the attack. It will be noted that nearly all these cases presented symptoms of lesion of the respiratory passages, and my own impression is that the early use of the vaccine in several cases prevented the infection from obtaining a footing in the lungs.

The frequency of albuminuria is noticeable, and I at first was afraid the vaccine was injuring the kidneys, but I have satisfied myself that a large percentage of the cases in the recent epidemic suffered from a slight nephritis, that called for a prolonged stay in bed.

The vaccine used was a mixed stock vaccine of B. influenzæ, streptococci, B. pneumoniæ, &c., prepared by Messrs. Parke & Davis according to Dr. Wynne's formula. The doses I gave were at first those recommended by Dr. Wynne, but towards the end of the epidemic I gave much larger doses with confidence and happy results.

Edenbridge, Kent. G. H. PENNELL.

Appointments.

Special Reserve.

Capt. R. L. Portway relinquishes his commission and retains the rank of Capt.

Territorial Force.

Capt. M. Coplans, O.B.E., D.S.O., to be Deputy Assistant Director of Medical Services and to be Acting Major whilst so employed.

2nd Lond. Gen. Hosp.—Capt. H. F. Lancaster is seconded for service with the Hampstead Military Hospital.

3rd Southern Gen. Hosp.—Maj. J. A. P. Price is restored to the establishment.

A.M.S.

Temp. Col. Sir W. Arbuthnot Lane, Bt., C.B. (Capt. R.A.M.C., T.F.), relinquishes his temporary commission on reposting.

R.A.F.

Medical Branch.—Major A. W. Iredell to be Lt.-Col.; *Capt. J. D. Bridger is transferred to the unemployment list.*

Dental Branch.—I. M. Thomson is granted a temporary commission as Captain.

Civil.

P. C. P. Ingram, M.B., B.S. Lond., has been appointed Medical Officer to the Skin Dept., Royal Gwent Hospital, Newport, Mon.

Change of Address.

Major P. C. P. Ingram, R.A.M.C. (T.F.), from Special Military Hospital, Co. Cork, to 23, Stow Park Avenue, Newport, Mon.

Capt. E. R. Saul, R.A.M.C., from India to c/o Holt & Co., 3, Whitehall Place, S.W.

Major F. E. Hutchinson, 37, Doughty Street, W.C. 1.

J. Wallace Kemp, 17, Kingston Hill, Kingston-on-Thames.

E. Stuart Taylor, 10, Cambridge Terrace, W.

F. N. Doubleday, L.D.S., from 4, St. Thomas's Street, S.E. 1, to 48, Welbeck Street, W. 1. (Tel. Mayfair 5221).

Major H. V. Leigh, M.B., R.A.M.C., Glyn Bargoed, Treharris, S. Wales.

Capt. F. Heatherley, R.A.M.C., Military Hospital, Ashton-under-Lyne, Lancs.

J. Dell Bridger, 50, Dartmouth Road, Cricklewood, N.W. 2.

E. M. Mahon, M.R.C.S., 45, Upper Brook Street, Park Lane, W. 1 (Tel. Gerrard 6366).

F. C. Newman, The Oaklands, Knowle, Warwickshire.

Honours.

BIRTHDAY HONOURS.

The following names of Guy's men, additional to those published in the last number of the GAZETTE, are included in the several supplements to the *London Gazette* announcing the bestowal of honours in connection with the King's birthday. The headings denote generally the sphere of operations in which the recipients were engaged.

Home Services.

K.B.E.—Lt. Col. (Temp. Col.) H. Davy, C.B. (T.F.)
Lt.-Col. Sir Shirley Murphy, Kt. (T.F.)
Maj. (Temp. Col.) Charters J. Symonds, C.B. (T.F.)

C.B.E.—Temp. Maj. & Bt. Lt. Col. F. S. Brereton.
Temp. Lt. Col. Maurice Craig.
Lt.-Col. Herbert S. French.

O.B.E.—Capt. J. A. Glover.
Capt. E. C. Hughes (T.F.)
Lt.-Col. E. W. Goodall.
Temp. Maj. (Act. Lt.-Col.) A. F. Hurst.
Maj. G. N. Pitt (T.F.)
Capt. R. P. Rowlands (T.F.)
Maj. R. H. J. Swan.

M.B.E.—Capt. W. J. Harris.

R.A.F.

O.B.E.—Capt. (Act. Maj.) M. R. Dobson.

India.

O.B.E.—Lt.-Col. E. J. O'Meara, I.M.S., Principal, Medical School, Agra, United Provinces.

France and Flanders.

C.B.E.—Lt.-Col. E. M. Pilcher, C.B., D.S.O.
Lt.-Col. C. E. Pollock, D.S.O.
Col. J. C. B. Statham, C.M.G.

O.B.E.—Temp. Capt. (Act. Maj.) L. R. Broster.
Capt. (Act. Maj.) J. Y. Moore.
Maj. (Act. Lt.-Col.) A. C. H. Gray.
Capt. (Act. Maj.) G. W. Smith.
Capt. (Act. Maj.) E. S. Taylor (T.F.)

To be Brevet Colonel—
Lt.-Col. (Act. Col.) C. R. Evans, D.S.O.
Lt.-Col. (Act. Col.) L. Humphry, C.M.G.

Italy.

O.B.E.—Cap. (Act. Maj.) M. Coplans, D.S.O. (T.F.)

Egypt.

K.C.M.G.—Col. (Temp. Maj. Gen.) R. H. Luce, C.B., C.M.G., A.M.S.

C.B.E.—Maj. & Bt. Lt..Col. (Temp. Col.) H. V. Bagshawe, D.S.O.

O.B.E.—Capt. (Act. Maj.) F. A. Barker, I.M.S.
Capt. (Act. Maj.) J. J. E. Briggs (T.F.)
Maj. W. H. Fisher (T.F.)
Capt. (Act. Maj.) A. E. Rayner.

Mesopotamia.

O.B.E.—Capt. J. M. H. Campbell (S.R.)
Lt.-Col. F. E. Fremantle (T.F.)

Balkans.

Temp. Lt.-Col. C. M. Wenyon, C.M.G.

Landon Out-Patient Tea Fund.

STATEMENT OF INCOME AND EXPENDITURE for the year ended March 31st, 1919.

Income.			£ s. d.
To Donations and Collections (as per list) ...			72 17 0
„ Interest on Invested Funds:			
5% Exchequer Bonds ...	7 5 0		
Deposit Interest	1 10 0		
			8 15 0
Total Income ...			£81 12 0
„ Excess of Expenditure over Income ...			3 9 8
			£85 1 8

Expenditure.	£ s. d.
By Cost of Tea, Groceries, Provisions, Fruit, etc.	21 7 1
„ Toys	50 11 0
„ Police Fees, Gratuities, etc.	8 2 0
„ Printing, Stationary, Postage, etc. ...	5 1 7
Total Expenditure ...	85 1 8

BALANCE SHEET, March 31st, 1919.

Liabilities.			£ s. d.
Accumulated Funds:			
Balance brought forward from last Account	266 14 10		
Less Excess of Expediture over income for 12 months to March 31st, 1919	3 9 8		
			263 5 2
			£263 5 2

Assets.			£ s. d.
Investments:			
£200 5% Exchequer Bonds at Cost ...			200 0 0
Cash at Bankers:			
On Deposit Account	50 0 0		
Current Account	13 5 2		
			63 5 2
			£263 5 2

Audited and found correct,
W. J. CURRY,
June 7th, 1919.

F. A. SHELDON, Treasurer,
Landon Tea Fund Committee,
Guy's Hospital Trained Nurses' Institution,
14, St. Thomas's Street, S.E. 1.
June 9th, 1919.

Specialities.

THE DENNISON MANUFACTURING CO., LTD., Sardinia House, Kingsway, London, W.C. 2.

The Dennison Crepe-Paper Bandages for securing dressings were used most extensively in the late war during the shortage of the usual material, and so satisfactory were the results that they proved a thoroughly efficient substitute for cotton fabric. The paper of which these bandages are made is totally different to the ordinary paper. They are made by a special process, and are wonderfully resilient and exceptionally strong. By the usual dry heat process they can be thoroughly sterilized.

These Crepe-Paper Bandages will be found serviceable in the majority of dressings, and in point of economy there is no question. A free sample bandage will be sent to doctors, matrons, or nurses on request.

We have received from Messrs. Clement & Johnson a sample of their Elixir "Yadil" Antiseptic. This elixir has been introduced to meet the demands of a number of medical men, for a form of "Yadil" antiseptic in which the allylic odour and taste are covered. It is half the strength of the liquid form, the dose being ʒi. to ʒii t.d.s., suitably diluted.

Elixir "Yadil" Antiseptic has been tested by a number of well-known specialists, and has been pronounced a clinical success, and with the pleasant lemon flavouring a palatable and useful form of medication for the sick room.

Cricket.

GUY'S v. CHARLTON PARK.

Played at Charlton Park. Guy's lost the toss and fielded first. Charlton Park started none too well, the first two wickets only scoring 17. Punch and Hollis, by steady cricket, brought the score to 58, when the latter fell to a catch at point off Shaw. Guy's bowling maintained the upper hand until the fall of the eighth wicket at 132. Martin then started hitting freely, with the result that the last two wickets added 58 runs. Guy's were set 191 runs to get to win in a little over two hours.

A good start was made, 53 runs being scored for the first wicket. The Charlton bowlers were keeping a good length at this period of the game, and runs were not easily obtained. The fourth wicket fell at 141.

In attempting to force the scoring, Shaw and Whitcombe sacrificed their wickets, and with Hunot bowled by Gill for a splendid 84, Guy's had 7 wickets down for 148.

The game was now in a very interesting position, as Guy's wanted 43 runs to win and had three wickets in hand. Wooldridge was unfortunately hurt and had to retire. The eighth wicket fell at 164.

Helder and Biddle batted well and obtained the necessary runs. The winning strike was made in the last over of the day.

Punch, Minno, and Martin batted well for Charlton Park. For Guy's, Hunot played very well, his 84 containing one five and nine fours. Wooldridge bowled well. Score:—

CHARLTON PARK.

Gill, b Wooldridge	1
Sargent, b Wooldridge	7
Punch, run out	35
Hollis, c Rose, b Shaw	18
Minno, b Wooldridge	49
Lambert, b Shaw	3
Birch, lbw, b Brown	3
Martin, c Rose, b Shaw	43
Wallace, b Wooldridge	0
Hammond, not out	9
Jennings, b Shaw	11
Extras	11
Total	190

Guy's bowling.—Wooldridge, 4 for 33. Biddle, 0 for 45. Helder, 0 for 11. Shaw, 4 for 58. Brown, 1 for 32.

GUY'S.

F. C. Hunot, b Gill	84
C. Vincent Brown, run out	24
H. A. Harris, lbw, b Hollis	0
G. P. Lindsay, c Minno, b Hollis	8
S. Rose, b Martin	22
G. D. Shaw, b Gill	2
D. M. P. Whitcombe, b Gill	4
L. B. Helder, not out	19
T. Wooldridge, retired hurt	6
L. Lyne, b Gill	3
F. J. Biddle, not out	15
Extras	9
Total (8 wickets)	196

GUY'S v. SUTTON C.C.

Played at Sutton on June 18th. Guy's lost by 4 wickets. Muir-Smith showed himself a valuable all round cricketer in his first appearance for Guy's. He took 6 wickets for 65 runs. Scores—

GUY'S.

C. Vincent Brown, b Jewell	10
G. D. Shaw, c Gullen, b Jewell	14
T. Woolridge, c Bilby, b Jewell	9
D. M. Whitcombe, c sub, b Runis	11
S. Rose, c Gane, b Jewell	7
—. Muir-Smith, c Runis, b Gullen	31
A. L. MacKay, c Thompson, b Jewell	9
L. B. Helder, c Gane, b Jewell	0
H. A. Harris, b Jewell	7
G. P. Lindsay, b Jewell	4
R. C. May, not out	4
Extras	12
Sutton Scored 245. Total	118

GUY'S v. OLD WESTMINSTERS C.C.

This match was played on June 14th. Guy's batted first, and from the outset runs came at a quick pace. After two-and-a-half hours play the innings was declared

closed at 293 for 4 wickets. Woolridge is to be congratulated on his first century for the Hospital, Our opponents started with a collapse, 5 wickets were down for 19 runs. Then came a stand for half-an-hour, but the side were eventually dismissed for 125. Biddle bowled very well; 5 wickets for 31. Scores—

GUY'S.

G. D. Shaw, run out ...	31
A. L. Mackay b Stones ...	28
T. Woolridge, no tout ...	107
G. P. Lindsay, b Elson ...	30
D. M. Whitcombe, c & b Stones ...	47
L. B. Helder, not out	19
Extras...	31
(For 4 wickets) ..	293

H. A. H. Harris, G. M. Stuart, F. J. Biddle, P. B. Skeels, M. F. Braun, did not bat.

OLD WESTMINSTERS.

G. L. S. Kohnstamm, b Biddle	0
G. Jackson, b Biddle	7
F. S. Fleuret, b Biddle	3
H. Elson, c Mackay, b Braun	0
C. R. Julian, b Braun	0
C. E. Stones, b Biddle	43
A. C. Feasey, c Shaw, b Biddle	34
R. C. May, b Skeels	0
— Randolph, b Skeels	4
— Munro, c Harris b Shaw	7
— Young, not out	10
Extras...	17
	125

Guy's are playing St. Mary's next Monday, June 30th, in the semi-final of the Inter-hospital Cricket Cup. The match will take place on the St. Thomas's Ground at Chiswick It is hoped that as many as possible will come to see the game.

Lawn Tennis.

The first round of the Inter-Hospital Cup Tie was played on St. Bart.'s ground at Winchmore Hill on Friday, June 13th.

Bart.'s team was too strong for our representatives and won by 11 matches to 3. Their first pair, Urwick and Johnson, only losing one set altogether.

This was our first match of the season, and lack of match play no doubt helped to contribute to this heavy defeat. Such a late start was made in reviving the Club that early matches were not obtainable, and getting the team together was handicapped.

The Cup has not been competed for since 1914, previous to which year Guy's had been the holders for five years consecutively.

The best individual performance on our side was Strawbaun's, who, after losing the first set and being 1–5, love 40 down in the third, managed to win the last set by 10–8. Scores:—

SINGLES.—A. Daneel (Guy's) lost to W. D. Urwick (Bart.'s), 3–6, 1–6; P. Krige (Guy's) lost to J. G. Johnson (Bart.'s), 1–6, 2–6; B. L. Laver (Guy's) lost to C. F. Krige (Bart.'s), 4–6, 2–6; G. D. Shaw (Guy's) lost to H. Summers (Bart.'s), 6–4, 4–6, 2–6; J. W. Schollum (Guy's) lost to McCall (Bart.'s), 3–6, 2–6; A. E. Strawbaun (Guy's) beat S. Orchard (Bart.'s), 4–6, 6–2, 10–8.

DOUBLES.—P. Krige and A. Daneel (Guy's) lost to W. D. Urwick and J. G. Johnson (Bart.'s), 4–6, 1–6; lost to C. F. Krige and H. Summers (Bart.'s), 4–6, 4–6. G. D. Shaw and J. W. Schollum (Guy's) lost to W. D. Urwick and J. G. Johnson (Bart.'s), 1–6, 5–7; lost to C. F. Krige and H. Summers (Bart.'s), 1–6, 6–2, 1–6; beat McCall and S. Orchard (Bart.'s), 6–2, 6–2. A. E. Strawbaun and B. L. Laver (Guy's) lost to W. D. Urwick and J. G. Johnson (Bart.'s), 3–6, 6–4, 2–6; lost to C. F. Krige and H. Summers (Bart.'s), 6–4, 5–7, 0–6; beat McCall and S. Orchard (Bart.'s), 6–4, 4–6, 6–1.

The 2nd team played their first match of the season at Honor Oak Park on Saturday, 14th June, v. Middlesex Hospital 2nd. This ended in an easy win for the Hospital by 7 matches to 2. The scores were:—

Whelpton and Gross (Guy's) lost to Bailey and Van Langenberg, 1–6, 2–6; beat Chena and Escourt, 6–4, 11–9; beat C. Cox and A. C. Tatham, 6–4, 6–2. Walters and Schlimmer (Guy's) beat Bailey and Van Langenberg, 6–3, 6–3; beat Chena and Escourt, 6–2, 6–2; beat C. Cox and A. C. Tatham, 6–0, 6–1. M. Mackenzie and T. A. Shaw (Guy's) lost to Bailey and Van Langenberg, 6–8, 6–2, 7–9; beat Chena and Escourt, 7–5, 6–2; beat Cox and Tatham, 6–0, 6–0.

Pass List.

Royal College of Surgeons, Edinburgh.

FELLOWSHIP—FINAL EXAMINATION, May, 1919.

H. H. Khan.

Births.

MOLLISON.—On June 13th, at 23, Devonshire Place, the wife of W. M. Mollison, M.Ch., of a son.

TIPPER.—On the 13th inst., at Thornbury Nursing Home, Southsea, the wife of Major F. J. Tipper, twin daughter and son.

Death.

DAVIDSON.—At Sea View, I.W., on June 13th, George Gillies Davidson, M.D. (Oxon.), son of the late George Davidson, of Mugie Moss, Aberdeenshire.

ED.—G. B. D.

GUY'S HOSPITAL GAZETTE.

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Reconstruction at Guy's.

A Committee of the Medical School has been sitting at frequent intervals during the past winter to consider what changes at Guy's are desirable to secure:—

(i.) The better preparation of medical students for the practice of their profession.

(ii.) A more effective use and co-ordination of medical skill for the benefit of patients under treatment in the hospital; and

(iii.) Constant advances in medical Science.

These are the three chief functions of a Medical School; in other words, teaching, practice, and investigation.

As the recommendations of the Committee have been recently approved by a meeting of all the teachers in the School, and it is intended that they shall come into force on October 1st next, it will be as well to give at once a general account of their character for the readers of the GAZETTE

Reforms are of two kinds: *external*, which depend on the action of outside bodies such as the Universities, Examining Boards, and the Board of Education; and *internal*, which can be effected by the action of the Medical School itself, and require only the sanction and support of the Governors of the Hospital.

There can be little doubt that the medical curriculum would benefit by being drastically overhauled throughout. As each of the Sciences has advanced on which the practice of medicine is based, they have been given an increasingly important place in the curriculum, with the result that the clinical teaching has been curtailed, and even so there is scarcely room for the very important but modern sciences of bacteriology and pathology.

An ideal arrangement for a five years' course would provide two years for the preliminary subjects, which would include physics and chemistry and the principles of biology and the elements of anatomy and physiology. Then there would be three years for the later subjects, which would include besides purely clinical medicine and surgery, applied anatomy and physiology and chemistry and also bacteriology and pathology. There can be little doubt that botany as taught now might be almost entirely omitted, and that the extensive dissections in zoology might be much curtailed. Further, the mass of unimportant detail in anatomy which is learnt for examination purposes by an effort of memory, but by no

effort of reasoning, and promptly forgotten, does more harm than good to the unfortunate medical student.

There is another criticism which may be brought against the present teaching of the earlier subjects. There is not a sufficiently close connection with the later subjects. For instance, students who have finished their chemistry course will still have no conception of the meaning of "hydrogen ion concentration" or of the properties of radium emanation. Physiology, which is the basis of medicine, may be defined as the application of physics and chemistry to biology. Hence the most recent advances in physics and chemistry are often applied immediately to medicine, but [illegible] they do not get a place in the syl[illegible] earlier subjects for medical stu[illegible] a[illegible] urgently needed is a Stand[illegible] of teachers in all subjects who [illegible] at least every five years to bring the syllabuses of the various examinations up to date.

All these changes, which are *external* reforms, will take time to bring about. At any rate, a beginning has been made. On the motion of one of our own teachers the Medical Faculty of London University are appointing a committee to confer with Oxford and Cambridge on these subjects. Let us hope that they will soon get to work.

The most serious criticism that has been brought against the teaching of the clinical period of study is the absence of the university atmosphere, by which is meant that clinical medicine and surgery is not being taught by men who are actually engaged in research. The explanation is obvious. Sir W. Hale White has recently pointed out that the pecuniary rewards of only moderately successful consulting practice have in the past been much greater than anything that a man can obtain through research, though the benefit to the community may be infinitely greater in the latter case.

The various London Medical Schools have been engaged in looking for remedies for this state of affairs. The London Hospital has definitely announced that they are going to appoint whole-time physicians and surgeons at appropriate salaries, each with his staff of paid assistants. It is an open secret that St. Bartholomew's and St. Thomas's and University College are adopting a similar line, and in some cases, at least, these "professors" will be whole-time men, while in other cases they will be obliged to devote the greater part of their time to their hospital work, and so greatly restrict their private practice.

In one respect we at Guy's are in an unfortunate position. The scheme of building which would have come into operation when war broke out has only just been started. It will be several years before the two extra floors on the top of the Medical Block are ready, and for the next year or two the beds in the hospital will be much reduced because Clinical is being pulled down. However, as soon as more medical beds become available, the University may be asked to appoint a professor, and so to start at Guy's a professorial clinic in medicine. Possibly a similar innovation will be introduced on the surgical side and in one or more of the special depart-partments. The future will decide.

However, it is thought that it would be a mistake to await the formation of a professorial clinic before initiating this kind of Advanced Medical Teaching at Guy's. Consequently Dr. Hurst has been asked to start this work at once. He will be given the title of "Director of Advanced Studies in Clinical Medicine." Besides taking on the duties of

full physician, he will still remain head of the Neurological Department, but an Assistant Neurologist will also be appointed. Dr. Hurst's beds will form a "Medico-Neurological Clinic," half of them being devoted to neurology and half to general medicine. The Assistant Neurologist and an Assistant Physician will work with him, each of them taking charge of a quarter of the beds in the clinic, Dr. Hurst looking after the remaining half. The ward visits will take place on five mornings in the week.

Once a week Dr. Hurst and the Assistant Physician will examine all their medical patients together, and once a week Dr. Hurst and the Assistant Neurologist will examine their neurological patients together. There will be clinical demonstrations and lectures open to all on four mornings in the week for six months during the winter from 12 to 1, and on one of these mornings there will be a combined demonstration with the corresponding surgeon or with one of the heads of the Special Departments. There will be ample opportunity for post-graduates and others who wish to take up some special line of medical investigation.

There will also be important changes in the other medical firms and in the surgical firms. At present the Assistant Physicians and Assistant Surgeons act rather as locum tenens to the Physicians and Surgeons than as Assistants. The "unit system," which is to be adopted implies the linking together of the two in one firm, each firm having its own beds and its own Out-Patient Department.

The head of the unit and his assistant will be associated together in teaching and in investigating cases. On the medical side it is hoped that once a week there will be a combined round, when cases of special interest will be discussed. The Surgeon and Assistant Surgeon will operate on the same afternoons, preferably in adjacent theatres, and in special operations they may be able to render each other assistance. The Assistant Physicians and Assistant Surgeons will take charge of a quarter of the beds of the unit. There will be a Registrar, House Officer, clerks, and dressers attached to each medical and surgical unit.

Criticism has been brought against the London Schools that the clinical teacher and the science worker revolve in different orbits, the one keeping solely to the wards, the other to his laboratory. It is true that there is plenty of laboratory investigation of a routine nature being carried out on behalf of patients, but this is usually arranged for by the House Officer, who fills up the proper form and receives it back again with the answer stamped upon it.

The closer linking together of the wards and laboratories will be brought about by arranging that members of the Junior Staff shall usually hold two appointments. There will be four Medical Registrars and four Surgical Registrars, one attached to each firm. These will be part-time appointments. The Registrars will be able to hold demonstratorships in the departments of the Medical School, *e.g.*, the Anatomical, Physiological, Pathological, or Bacteriological Departments, or they may hold Clinical Assistantships in the various Departments. The association of wards and laboratories will be further [illegible] the creation of eight new posts. The holders of these posts will be called Medical or Surgical Assistants. There will be one attached to each firm. They will have no routine duties in the wards, but they will spend their time carrying out medical or surgical investigations under the supervision of the head of the firm and the head of one of the laboratories. The status of the post will be equal to that of Medical or Surgical Registrar. The Assistants, like the Registrars, may hold other part-time appointments in the Hospital or Medical School. Further, these new appointments will be open to men from other Schools. Post-graduates who come to Guy's for shorter periods of study, and wish to carry out clinical investigations, will likewise be given the title of "Assistant" (unpaid) so as to obtain a status in the wards.

When all these posts are filled, there will be besides the "Medico-Neurological Clinic," three medical firms and four surgical firms, each firm consisting of two members of the Staff, a Registrar, an Assistant House-Officer, and a number of clerks or dressers. The present Assistant Surgeon's firm will no longer exist as a separate entity. Each firm will be com-

plete in itself, carrying on its own Out-Patient Department in close association with its In-Patient Department. In future, Medical and Surgical Out-Patients will be held in the morning. On the surgical side each firm will take its share in running the Front and Back Surgery, will superintend its own fractures and minor operations, and will be responsible for its own emergency surgery work during "Take-in" Week. The Registrar or Assistant may be appointed to undertake the duties for his firm now carried on by the R.S.O.

The Obstetric Department has been long handicapped from want of beds, and it is hoped that the number will be increased at the earliest opportunity. There can be little doubt that this subject provides a wide field for investigation at the present time, and it is essential to improve the teaching here

Realising these facts, the Hospital is creating a new appointment called "Midwifery Registrar" at a salary of £250 a year, with £50 for rooms. Besides teaching, the Registrar, who will be resident in St. Thomas's Street, will be available for cases of difficult labour, and he will be required to carry out investigations on the diseases of pregnancy, etc., and will also work in collaboration with the Children's Department. It will be an excellent opportunity for doing valuable work, though probably the best results will be obtained by a man who has had some special pathological or physiological training.

We have long waited for a Children's Ward at Guy's. As a temporary measure Miriam is being adapted for this purpose, but the cots will still be retained in the Medical and Surgical Wards, at any rate for the time being.

Other contemplated changes refer chiefly to students' appointments. In spite of the fact that "Clinical" Ward is being pulled down, it is hoped to revive the appointment of "Clinical" as soon as possible. There will probably be eight clinicals, and they will take the place of medical ward clerks in one of the four medical firms, including the "Medico-Neurological Clinic." Each firm will undertake the duties of "Clinical" in turn for a period of three months, the medical ward clerks being attached to the other three units. The House-Physician corresponding to the firm in charge of Clinical, who will have less to do than the other House-Physicians, will, in addition, look after the Children's Ward.

The "Probationary Clinical Course" of three months' duration, to be held four times a year, will be a new feature of the medical curriculum. The present arrangement by which clerks or dressers have to leave the wards to attend Bacteriological or Pathological Classes is unsatisfactory. In future all this work will be carried out three months before entering the wards, and the student will also get instruction in Minor Medicine and Surgery (including case-taking), in Pharmacology, Clinical Chemistry, and Clinical Pathology. Men from Oxford and Cambridge who have already been through such a course will not, of course, have to do it again on arriving at Guy's. This course will take the place of the appointment of Surgical Ward Clerk. As at other hospitals, the dressers will be expected to write the reports on their cases in the Surgical wards. It would obviously be of great value to the hospital if marks for good report writing in the medical and surgical wards were given in the final examinations; but this is obviously an *external* reform.

It is hoped that the examining bodies will finally abolish all systematic lectures which have been in abeyance during the war. In medicine and surgery their place could be taken by an increased number of clinical lectures and demonstrations. E. P. P.

Papers by Guy's Men.

Capt. S. W. Coffin, R.A.M.C.: Notes on a case of antiseptic bite.—*Lancet*, June 28th, 1819.

F. E. Shipway, M.D.: Case of sudden collapse during laparotomy under ether; treatment by heart massage. Proc. R.S.M., June, 1919, Anæs. Sect., p. 17.

— Case of tonsillectomy in a man weighing 23 st.—*Ibid.*, p. 18.

— Case of abdominal section in a man with a thoracic aneurysm.—*Ibid.*, 22.

H. W. Barber, M.D.: Case for diagnosis.—*Ibid.* Dermat. Sect., p. 37.

— Two cases of granulosis rubra nasi in boys.—*Ibid*, p. 40.

— Alopecia of the scalp and eyebrows associated with Graves' disease.—*Ibid*, 41.

C. E. Iredell, M.D., A. D. Marston and G. Bellingham Smith, M.B., B.S.: Diathermy in gynæcology.—*Ibid*, Sect. electro-therapeut., p. 16.

C. E. Iredell, M.D.: Notes on diathermy apparatus. *Ibid*, 18.

— and Philip Turner, M.S.: The treatment of malignant disease, by Diathermy and Fulguration.—*Ibid*. 23.

— and C. M. Ryley: Diathermy in Diseases of the eye.—*Ibid*, 31.

— Diathermy in abdominal disorders.—*Ibid*, 34.

H. W. Barber, M.D.: Case of acne complicated by intestinal stasis, in which a general improvement was effected by diathermy.—*Ibid*, 37.

Passim.

IT is with great regret that we have to report in these pages that the death of Allan Bell took place on Saturday, June 28th. He died, unfortunately, too soon to receive the testimonial that was intended for him, but he was very glad to know that so many had remembered him and to read some of the very appreciative letters that were sent by old Guy's men. Readers of the GAZETTE will be glad to know that the sum reached was £130. The money and the testimonial will be forwarded to his widow.

WE are sure that all readers of the GAZETTE will join us in expressing the sincerest admiration at the continued valuable work of the Guy's Hospital Ladies' Association during the past four years of war. The Annual Report printed elsewhere in this issue will convey some idea of the difficulties under which they have laboured. During this period many members have given their services, not only to Guy's, but to Military Hospitals as well. In spite of this their work in the service of Guy's has been carried on without a break. In addition they have endowed two cots in perpetuity in the Hospital wards. The Association now supports six beds in Maternity Ward, and propose to support two more cots during the coming year.

The greatest regret is felt at the retirement of Mrs. Lauriston Shaw as secretary of the Association. Mrs. Shaw has held this post ever since it was founded twenty-four years ago, and the Association, that has now become an indispensable part of the life of the Hospital, chiefly owes its continuous and increasing success to her administration. We should like to offer our congratulations and best wishes to Mrs. Philip Turner, who has been nominated to succeed Mrs. Shaw.

READERS of the GAZETTE will be glad to know that the new Salomons Welfare Centre is now nearing completion. It is hoped that it may be opened in September. It may, perhaps, be of interest to recall briefly some of the facts regarding the foundation of the scheme. The late Mr. Leopold Salomons left the sum of £10,000 as a Trust Fund separate from the Funds of the Hospital for the maintenance of an Infant Welfare Centre in connection with Guy's, the Trust to be administered by the Hospital through an Advisory Committee appointed annually from amongst the Governors and Hospital Staff and others interested in Infant Welfare. The Hospital provided three houses rent free in Newcomen Street for this purpose, and these are now being converted into an Infant Welfare Centre. Out of two other houses near by a creche is at present being constructed. Briefly, the Centre will have the following plan.

The Welfare Centre will have a Consulting Room, a Waiting Room for Children, a Mothers' and Infants' Waiting Room, a Dressing Room, and a Secretary's Room, while for the Staff there will be bedrooms, a reading room, sitting-room, and dining-room. The creche will have a concrete roof for a children's playground, infants' cots, a sick room, and rooms for the staff. We are unable at present to give more than these scanty details, but we hope at an early date to publish a full account of the scheme. The Centre will, in addition to its great usefulness to the district, be a very valuable asset to future Guy's men by providing opportunities for research into the cause and prevention of infant mortality.

WE should like to draw the attention of readers to a letter published in another page from Prof. A. E. Boycott. Prof. Boycott suggests that when Clinical is replaced, as it ulti-

mately will be, by new buildings, a tablet should be erected on the site of Sir Thomas Stevenson's laboratory. We do not think that there can be any who will not agree that a spot famous in medical literature and associated with some of the greatest of Guy's traditions should be fittingly and permanently commemorated.

THE following "Blues" and "Half-Blues," which should have been given in 1914, have now been awarded:—

LAWN TENNIS.—*Full Blue:* N. Garrard, C. E. Petley.

SWIMMIMG.—*Half-Blue:* A. F. Guinness, F. J. Ordish, L. G. Whelpton, A. L. Anthony, R. Ralph.

ATHLETICS.—*Full Blue:* K. F. McAlpine.

CRICKET.—*Full Blue:* A. C. Coxon, L. H. Gilbert, H. M Gray, H. Sterne-Howitt, G. P. Lindsay, D. M. Whitcombe.

RUGBY FOOTBALL.—*Full Blue:* C. H. Laver.

ASSOCIATION FOOTBALL.—*Full Blue:* D. A. Bevis, E. S. Phillips, H. V. Stebbings, F. E. Welton.

HOCKEY.—*Full Blue:* B. Burnside, G. L. Cutts, J. N. Martin, H. L. Peregrine, J. F. Venables.

Guy's Hospital War Memorial.

The Committee formed to collect funds for the establishment of a permanent Memorial in connection with the War have endeavoured to find out the character of the Memorial which would appeal most to the subscribers. Certain objections have been raised to some of the suggested proposals set forth in the first appeal issued in November, 1918. It appears that there are very few, if any, widows and orphans left by Guy's men who have fallen in the war, and few men have been permanently disabled; but it will be considered as a first charge upon the Guy's Hospital War Memorial Fund to help the education of children of Guy's men who have fallen or died in the war, should such help be required.

There is, moreover, the Royal Army Medical Corps Auxiliary Fund which helps in a generous manner the widows, and also assists in the education of orphans and of children of those who are permanently disabled.

As it therefore appears that little money will be required for the above primary obligation of the Fund, three additional proposals are now placed before those who have subscribed, or may wish to subscribe, to the War Memorial:

1. A portion of the Fund to be devoted to the new "Clinical" Ward shortly to be built, which should be called the "War Memorial Clinical Ward," and have inscribed upon its walls the names of the Guy's men who have lost their lives owing to the War. It is thought by some that "Clinical" Ward, associated as it is with old and great traditions, might specially appeal to old Guy's men, and also to parents, and relations, as a most fitting place in which to inscribe the names and to commemorate the deeds of those who have died in the service of their country and hospital.

2. The adornment of the Dining Hall of the College, including memorial panels bearing the names of the Guy's men who have lost their lives in the war.

3. A portion of the Fund to be allocated to form the nucleus for endowment of a Dental Research Scholarship.

It has been decided to close the Fund on the 30th September, 1919, and to call a General Meeting of the subscribers in October, 1919, to decide upon the form or forms which the Memorial is to take.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

From Cradle to School.*

WE wish to offer our sincere thanks and congratulations to the writer of this book. Dr. Cameron combines accuracy of observation with a vividness of expression that does nothing to detract from a literary style which is seldom seen in current medical writings. As we read, some memory of our childhood leaps to the mind, or we see again some little scene which has amused or pained us in the Out-Patient Department or among the children of our acquaintance.

We have always thought that the description in Dr. Taylor's "Medicine" of the child during a fit of coughing when suffering from pertussis is one of the best things in medical literature. Similar pictures abound in the pages of the book that we have before us. Thus, in the chapter on Want of Sleep we read :—

> "The hour before bed-time is almost universally the most interesting of the whole day for the child. Then the baby, with his best frock on, and books and toys, is the centre of interest in the drawing-room, till the clock strikes and the nurse appears at the door. Suddenly it is all over, and inexorable routine sends him off to bed."

Or, again, in speaking of the failure of the extinct candle to induce sleep :—

> "But with nervous, highly-strung children I doubt if this Spartan conduct is commonly successful. Often if the attempt is made, the troubled mother, listening to all these heart-breaking sobs, can bear it no longer, and goes back to the side of the cot to soothe and persuade him. Then certainly the longer she has restrained her natural inclination, the longer the child has sobbed himself into a pitiful little ball of perspiration and tears, the more difficult will be her task in quieting him, the stronger will be the impression formed on the child's mind, and the greater will be the suggestion which will act under the same circumstances to-morrow."

Such an anecdotal method is particularly suited to the teaching of diseases of children. It at once rouses that sympathy of the adult for the child, which the latter recognises instinctively and which gives him that confidence so necessary to his successful handling; if the reader does not respond to Dr. Cameron's little stories, he may learn the reason of his want of success when dealing with children.

Dr. Cameron begins by discussing his subject in reference to the young child during a period which corresponds roughly to that between the eruption of the first and second sets of teeth. He then gives us a chapter on early infancy, and thence turns to the more extended period of the second dentition. Much, however, that was written in the earlier chapters is still applicable to this older age. Indeed, the book brings home to us how truly is the child the father of the man, for many things he tells us would form good guides to our own daily life. Dr. Cameron recognises this himself when he writes :—

> "Even grown-up people, when their nerves are on edge, are apt to be obsessed by uncontrollable impulses, or by vague and nameless apprehensions, and surely all have learnt the support they gain from contact and conversation with some one strong and sane, who treats their worries in such a matter of-fact way that immediately they lose their power and become as of no account."

After the last four years many of us appreciate the truth of this, and, as we read, will remember some time when we felt ourselves overburdened with the anxieties of the moment and how those anxieties melted into thin air as a result of a short visit to one who had much more to bear. Perhaps the chapter on "Toys, Books, and amusements" brings this best home to us. How often have not we seen the "elaborate and expensive" toy or the "costly or realistic" horse broken up and thrown aside in favour of a piece of old metal or a rag doll? When we are selecting the toy for the birthday present or taking the pantomime tickets for the holiday treat we deceive ourselves into thinking that we are doing it entirely for the children, whereas in reality we are grasping the opportunity to take up again those childish things that we put away when we became men. Some of us remember dull, mid-term holidays spent at the British Museum

* "The Nervous Child." By Hector Charles Cameron, M.A., M.D. (Cantab), F.R.C.P. (Lond.), Physician to Guy's Hospital, and Physician in Charge of the Children's Department. Henry Frowde, Hodder and Stoughton. Oxford Medical Publications, pp. 202. 6s. net.

or Westminster Abbey, to which we were taken owing to a dearth of country cousins; for, like true cockneys, our parents would never have been seen within any of the national monuments of our city unless they were showing them off to children and strangers.

The book is a sign of the times. After 1870 advances in medicine were so taken up with the seeds of disease that the soil in which the disease grew was relatively forgotten; then when theories of resistance and immunity began to arise, the changes taking place in the soil rather than the soil itself was studied. Now we are returning to that observation of human nature which is an essential part of all success in medicine whether we practise as a consulting surgeon, a general practitioner, or a regimental medical officer. Dr. Cameron's power of combining his observation of the character of the little ones with his knowledge of organic disease is best shown in the chapters on "other signs of nervousness" and on "enuresis."

The book is also a sample of the best type of Guy's teaching. There is no dogma in it, especially of treatment, no rules of thumb are laid down by which a definite diagnosis can be made; rather the lines of thought along which the mind should travel are sketched out, and methods of treatment are indicated and suggested rather than imposed upon one. From other institutions books may be written in which something is ordered for the patient, and if at the end of an hour and three-quarters a stated change has not occurred some other definite dose of a drug accurately measured to parts of a minim has to be administered. Such has never been the teaching at Guy's, where the effort has always been to make the student think, and to develop an elasticity of mind which may not be of such use with the seldom seen, text-book pathological lesion, but which is of inestimable value in the varying phases of disease as seen in any walk of life. This teaching is seen in the great Guy's books such as Hilton's Rest and Pain, Fagge's Medicine and Taylor's Medicine, as well as in Jacobson's Operations of Surgery, and we are glad to see the tradition being kept up to the present day.

We hope that this book will be widely read, not only by medical students and doctors, but also by nurses, masseuses, and those social workers who are becoming such an important factor in the work of our hospitals and of the school clinics. We feel that all these will gain in their power of handling the younger patients who pass through their hands. They will find little characteristics of their own picked out and shown to them as undesirable.

To "parents and nurses, schoolmasters and mistresses" the book will also appeal, witness the following:—

> "We all hate the tell-tale child, and when a boy comes in from his walk and has much to say of the wicked behaviour of his little sister on the afternoon's outing, his mother is apt to see in this a most horrid tendency towards tale-bearing and currying of favour. She does not realise that day by day, when the children have come in from their walk, she has asked the nurse in their hearing if they have been good children; and when, as often happens, they have not, the nurse has duly recounted their shortcomings, with the laudable notion of putting them to shame, and of emphasising to them the wickedness of their backsliding;—and this son of hers is no hypocrite, but speaks only as all children speak, in faithful reproduction of all that he hears. These grown-up persons who are in charge of the children must realise that the child's vocabulary is their vocabulary, not his own. It is unfortunate, but I think not unavoidable, that so often almost the earliest words that the infant learns to speak are words of reproof or chiding, or repression. The baby scolds himself with gusto, uttering reproof in the very tone of his elders, 'No, no,' 'naughty,' or 'dirty,' or 'baby shocked.'"

For one who has had no medical training, however, the book is a bit too technical in places, and so we may hope that Dr. Cameron may find time to write a companion volume for these readers; but until he does we may confidently tell them there is so little in this they will not understand that they should read it for the much sound advice which they will understand.

T. B. L.

Papers by Guy's Men.

W. Sampson Handley, M.S.: On the mode of spread of cancer in relation to its treatment by radiation.—Proc. R.S.M., June, 1919, Sect. Electro-therapeut., p. 41.

S. W. Daw: Orthopædic effects of gunshot wounds. *Oxford Medical Press.*

Guy's Hospital Dental Society.

A General Meeting of the Society was held on Thursday, June 5th, 1919, at 12 noon, to elect officers for the Session 1919-1920, and to reconsider certain rules of the Society. Mr. M. F. Hopson presided.

The following officers were elected:—

President—Mr. F. Bocquet Bull.

Vice-Presidents—Mr. M. F. Hopson, Mr. E. C. Hughes, Mr. F. N. Doubleday, Mr. F. J. Pearce.

Hon. Treas.—Mr. C. G. Atkinson.

Hon. Sec.—Mr. W. H. Willis.

Committee—Messrs. C. de A. Birch, F. J. Myers, C. H. Edney, K. Hooper.

The following alterations in the rules were proposed and adopted:—

Rule 5 was altered in such a way as to allow of the representation of the first and second year students on the committee, instead of restricting the nominations to students of the third and fourth years only.

The duties of the Dental Correspondent were transferred to the Hon. Secretary.

Votes of thanks to the retiring President and Secretary were proposed and carried unanimously, while a special vote of thanks was given to Mr. F. B. Bull for his services in the organisation of the Annual Dinner of the Society.

Congratulations were offered to Mr. Hopson on his election to the presidency of the British Dental Association for the ensuing year.

A cricket match on June 9th, between sides chosen from the Dental School and the Medical School, resulted in a somewhat easy win for the Dental School. The Medicals, who batted first, lost their early batsmen in quick succession to a series of catches on the off, and had eight wickets down for less than 40 runs. Some free hitting for the last two wickets brought their score to 78. R. van Geuns and R. Payne shared the wickets.

The Dentals scored 227 in about an hour and three-quarters. Of these, A. L. Mackay made 32, D. Eglington 44, and R. van Geuns 48.

It is hoped to arrange another game between sides more fully representative of the two Schools.

The London Intercollegiate Orchestral Society.

A preliminary General Meeting will be held in the Engineering Society's Rooms, University College, Gower Street, on Tuesday, July 1st, at 5.45 p.m., to discuss the possibility of an University production of a Gilbert and Sullivan Opera.

All interested are cordially invited, and it is hoped, in order that the meeting shall be representative, that as many as possible from the various Colleges will attend.

B. COCKSFEISER, Hon. Sec.

Guy's Hospital Ladies' Association.

Report of the Committee for the year ended March 1st, 1919.

THE Committee is pleased to be able to present its report of the Association's work during 1918 at a time when all the members are rejoicing at the cessation of the war which has overshadowed the nation for the past four years. The members have loyally and generously supported the Association during these critical times, thus enabling its valuable work to be carried on and much needed help to be given to the sick amongst the civilian population. The number of members is now 1144, of whom 835 belong to the Branches and 309 to the main body. All the 18 Branches have continued in active work this year, but several of the Secretaries are now resigning and unless a successor in each case can be found the Branch must be relinquished. Mrs. Astley Roberts finds it impossible to continue the Eastbourne Branch which she founded and has conducted so successfully. Miss Daniel who has acted as Secretary to the Norfolk Branch for many years is also obliged to resign. If any member of the Association will undertake the duties or can find a successor to either of these ladies the Committee will be grateful. Mrs. Thorpe has resigned the Secretaryship of the Balham and Clapham Branch, owing to increasing claims upon her time. The Committee is pleased to hear that Mrs. M. Henderson-Scott, the granddaughter of the original founder of the Branch, has consented to continue the good work. All the Branches show evidence of increased vitality, and now that the deadening influence of the war is removed several of the Secretaries are formulating schemes for possible future expansion.

The London working-party was re-organised at the beginning of last season, and as a temporary war measure, has been held on Fridays throughout the winter at Mrs. Fawcett's house, the usual tea being abandoned owing to the food restrictions. The attendance has been smaller than usual, an average of only 13 but notwithstanding this, 178 garments have been made, a result which compares very favourably with pre-war days. The Committee is most grateful to Mrs. Fawcett for her kindness in giving up her rooms and thus enabling the working-parties to be continued. She has also supervised and done a good deal of the cutting-out ably assisted by Lady Fripp, Mrs Gilfillan, Mrs. Rowlands, Mrs. Steward, Mrs. Spon, Miss Taylor, and Lady Hale White, to whom thanks are also due.

Mrs. Rowlands still acts as Secretary to the Junior members' Branch which consists of 164 members, who contribute £21 11s. 8d.

The visiting of patients in the wards has suffered greatly during the last few years owing to the urgent claims of the war. It is hoped, however, that this branch of the work may soon be revived, and that some

of the old visitors will resume their labours, and new recruits be enlisted. Those who have been visiting this year are enumerated below:—

VISITOR.	WARD.	DAY.
Mrs. Cosmo Bonsor	Naaman ...	Friday.
Hon. Mrs. Henry Molyneux ...	Mary ...	Saturday.
Miss Webster	Lazarus ...	Thursday.
Mrs. Stanley Mason	Martha ...	Friday.
Mrs. Henderson, & Mrs. Ashdown	Charity ...	Thursday.
Mrs. Lewitt	Esther ...	

Members will remember that on the outbreak of the war immediate use was made of the Ladies' Association and an appeal was issued on behalf of No. 2 General Hospital for sick and wounded soldiers at Chelsea. The generous response made by the members enabled the work to be carried on efficiently at a time when comforts for military hospitals were greatly needed. The two wards at Guy's set apart for officers and for new recruits respectively were also supplied with many extra comforts. In course of time the help given by the Association became less necessary on account of the numerous depots which were opened all over the country to supply military hospitals, and to avoid overlapping no more special appeals were made. Several kind friends, however, continued to send various welcome gifts such as garments, invalid delicacies, Christmas fare and presents. These were gratefully received and were acknowledged by the matron: No. 2 Hospital is now (April) being demobilized. During its existence, 40,500 soldiers have been treated there.

The Committee deeply regrets to record the loss it has sustained by the death, after a long illness, of the Chairman, Dame Edith Benyon, who held office ever since the foundation of the Association in 1895. Her sympathy and active help will be greatly missed and especially so by those who have been brought into intimate relations with her.

Owing to removal from London, Mrs. Lauriston Shaw, who has been the Hon. Secretary since the Association was started 24 years ago, has been obliged to resign. Mrs. Philip Turner has been nominated to succeed her, and her election will be duly proposed at the Annual Meeting. The Committee feels sure that all the members will rally to the support of the new Secretary, and it hopes that under her guidance the Association will still further extend its useful work.

With regard to finance, the position remains satisfactory, the amounts received being but little less than those of last year. The decision to resume printing the report was taken after due consideration and has the approval of the local Secretaries. The expense involved will be considerable, but in spite of this the Committee is able to recommend that £200 should be devoted to the support of 6 beds, and £50 to the support of 2 cots. One cot is still entirely supported by the West Herts Branch, the funds for the last two years having been raised by an entertainment kindly organized by Mrs. Rogers. Another very welcome contribution of £40 was sent through Mrs. Eason, being the proceeds of a garden fête arranged by Mrs. Smith and Mrs. Hinchliffe at South Norwood. The Committee offers its thanks to these ladies and to others who helped to make the function a success. The Secretary was invited to attend and to speak on the work of the Association. Through the knowledge thus given several new members were secured. It will be remembered that at the last Annual Meeting the sum of £500 which the Association had gradually accumulated was handed to the President of the Hospital for the permanent endowment of a cot. The Committee recommends that a fund should now be started, to endow a cot in the new children's ward which is soon to be instituted. The Committee is of opinion that it is a sound financial arrangement that the ordinary expenses and regular annual grants should as far as possible be met by the steady annual income from members' subscriptions and donations, and that all incidental large sums which are contributed from time to time should be devoted to this endowment scheme. At the present time the sum of £50 has been placed on deposit, in the hope that this idea will meet with the members' approval. This deposit is made up of £40 from the South Norwood fête and £10 from the sales of work got up by the Hon. Cicely and Phyllis Goschen.

Now that the urgent war claims which have occupied so much of the members' attention are happily over, it is hoped that a period of wider usefulness and activity lies before the Association, which may lead to even greater developments than have taken place in the first 24 years of the Association's existence. It is interesting to compare the first annual report with that presented to-day. In 1895 there was a membership of 95—and the income of the Association amounted to £27. The growth has been striking, but when consideration is given to the national and even imperial character of the work of Guy's Hospital and the world-wide distribution of its former pupils and nurses, it must be recognised that the possibilities of further extention of the Association's activities are almost unlimited. Fresh departments are constantly being opened at the Hospital which call for additional help.

The success of the Branches, so excellently organised by the local Secretaries, indicates that the formation of additional branches is the direction in which extension can best be secured. There must now be large numbers of people who have gained practical knowledge during the war of the needs of Hospitals in the numerous war Depôts which have supplied the Military Hospitals. It should be possible to enlist the active help of some of these skilled workers, and the Committee appeals to the members to endeavour to arouse interest in the Association amongst any such with whom they may come in contact.

No report would be complete without some reference to the work of the local Secretaries, to whose self-sacrificing zeal so much of the success is due. Their efforts have been ably supported by the individual members, and to all the thanks of the Committee are given for their continued help and interest.

Signed on behalf of the Committee,

MABEL G. BONSOR, Chairman.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR:—I thought perhaps the following account of the treatment of a severe case of the Toxæmic Vomiting of Pregnancy might be of interest, and I wondered if it would elicit reports from others as to success with similar or other modes of treatment in this comparatively rare but interesting condition.

Mrs. P., æt. 27, first became known to me on June 6th last, when her mother consulted me about her on account of her vomiting. I prescribed somewhat usual drugs for such cases, a mixture containing Ac. Hydrocyan. dil., Bismuth and Morphine, however, these drugs apparently had no effect, for three days later the husband came to me and said his wife was continuously vomiting. I speedily went down to the patient's house, she was in bed and looked very tired, wan, and ill. I obtained from the patient herself the following history: She had had one previous pregnancy which, however, had a fatal termination at full term, for the child, a healthy one of 10½ lbs., died from some obscure reason a day later, indeed the whole pregnancy is clouded in mystery for the patient remembered nothing of it for three days, this was in December, 1915; during the early months of this first pregnancy there had been considerable vomiting but not to be compared in severity with this present pregnancy. The patient was then three months pregnant and vomiting commenced early in the second month and had become progressively worse, so that for the last three weeks no food was retained and vomiting continued all day and was even worse at night, this being a characteristic feature, I believe, of the condition. The patient's sister, a trained nurse, had finally persuaded her to see a doctor, being confident that the vomiting was far in excess of the common vomiting of pregnancy, and so indeed it was. On examination the abdomen was intensely and acutely tender as the result of the frequent vomiting, the tongue was dry and furred, the patient had sunk eyes and an anxious look, the pulse was rapid but of fair quality. I, perhaps foolishly, experimented again with drugs with the exhibition of Cerian Oxalate in gr. iii doses, much vaunted as it has been for this condition, however, it did no good and the patient became certainly worse. The two succeeding days I visited the patient and finally I was persuaded something drastic should be done, the patient was extremely anxious to continue the pregnancy if possible, and I decided to try the treatment described by C. S. Bacon in the Journal of the American Medical Association, 1918 (1). I had made up my mind the case was one of severe toxæmia, and later when the patient was in hospital another doctor and myself both decided that the neurotic element could be definitely eliminated. I was fortunate in being able to move the patient into the local Cottage hospital, where she had every care. I started the treatment the afternoon the patient arrived, she was placed in a corner bed, well screened off from the rest of the ward in absolute quiet. Firstly a cleansing enema was given consisting of soap and water, and the patient was forbidden absolutely anything by mouth at all, nourishment being given solely by nutrient enemata. The composition of the rectal feed is the following—on no occasion was it not retained and it caused but slight irritation around the anus after prolonged use—as a formula for a nutrient enema it is worth knowing:

Glucose	50
Alcohol	50
Calcium Chloride ...	0.3
Sodium Bicarbonate ...	3
Sodium Chloride ...	4
Sodium Bromide ...	5
Water to	1000

1500 cc. of this is made up and given daily in three or four different feeds, preferably the former, by this means 825 calories are given daily. To the last feed at night I added Tinct. Opii. m. xx, and it was extremely useful in inducing sleep. The formula is very similar to that used by Bacon in America, but he only suggests tinct. opii. mx., I think the larger dose quite safe and more useful, he, too, does not give both sodium chloride and sodium bromide in the formula, but I found the use of 5 parts of sodium bromide seemed to have some sedative action. I gave the cleansing enema for two mornings following at 8 a.m., and then every other morning, this seemed to suffice and the fluid was never returned, I emphasize this, I had wondered if the alcohol was useful in creating a greater tolerance of the bowel wall, 5 % is sufficiently strong, I think, for continued rectal use, and it certainly is a simple and efficient way of giving an energy-forming substance per rectum for it is readily absorbed. The vomiting persisted for three days though much lessened in severity, but by this time the patient was extremely exhausted, the pulse was rapid and irregular; however, four-hourly injections of digitalis worked wonders, and though I had been seriously contemplating the induction of abortion after consultation with another practitioner, the pulse slowed down and the dropped beats previously so frequent became few and far between. From that time on the patient improved steadily, and on the ninth day after treatment was commenced vomiting and retching ceased entirely. All fluids had been withheld throughout, and, happily, latterly the thirst had somewhat allayed; on the ninth day the patient craved for some strawberry juice, and I allowed the juice of about three strawberries. When retching had ceased for two whole days and nights, feeding by mouth was cautiously commenced with albumen water, fruit juice, then fruit jelly, Benger's food, and so forth until slowly a normal diet is being resumed. The result is most encouraging and the patient is of course delighted—she was, happily, extremely good and patient; a relapse is always possible, but after several days I do not now fear one. C. S. Bacon in his account says that with similar treatment as the above abortion is practically never necessary in cases of hypercinesis. I commend my experi-

ence to your readers for it is the type of case which sooner or later comes to every practitioner, and it may be that the saving of the child life in the particular case is of the first importance, to me it is of the greatest importance always, there is enough post natal waste of infant life so that surely the pre natal sacrifice of life should never be undertaken without all that is possible being attempted to save that life.

I am, yours faithfully,
HAROLD O. LONG.

Alton Court,
Ross-on-Wye,
Herefordshire.
24th June, 1919.

SIR,—The other day I noticed—and the GAZETTE reminds me—that clinical is coming to its end, and with it the old laboratory of Sir Thomas Stevenson. In its day this laboratory was a very famous place, and its site must always be a landmark in the history of forensic medicine in this country. May I suggest that in the new building a tablet should be incorporated commemorating the former existence on the spot of so distinguished a place?—Yours, etc.,

A. E. BOYCOTT.

17, Loom Lane, Radlett,
30th June, 1919.

DEAR SIR,—I hasten to apologise to Mr. R. H. Jocelyn Swan for having described his method of operating upon a tuberculous kidney incorrectly. There are two objections which may be raised to Mr. Swan's operation, as described in "Guy's Hospital Reports" 1910, Vol. lxiv., p 59, and quoted by the author in his letter to you of June 19th, 1919.

Firstly—Mr. Swan leaves a broad bridge of muscle undivided—to Mr. Swan this is, therefore, a bridge of size; to me it is a bridge of sighs—it completely limits the upper incision at its lower extremity, and this is a great disadvantage in cases of extirpation of a tuberculous kidney by the ordinary route.

Secondly—Mr. Swan tucks the kidney down into the lower part of the wound, and then proceeds to remove it, and the ureter through an inguinal incision. I cannot think that to tuck a tuberculous kidney down into connective tissue which is, presumably, not tuberculous, is a sound surgical proceeding, and I am surprised that Mr. Swan has had only one case of "tuberculous infection of the inguinal wound."—Yours faithfully,

A. R. THOMPSON.

DEAR SIR,—Since my return to the Library, I have discovered that the enclosed list of books are missing from our shelves. They are nearly all reference books and all the more valuable, as they are in constant demand.

I have been requested to forward you the enclosed list hoping that the gentlemen who have these books in their possession will return them at the earliest opportunity.

On the other hand I need hardly say how much we would appreciate presentations, especially modern textbooks.—Yours faithlully,

J. H. E. WINSTON,
Librarian.

BOOKS MISSING.

Gardner's Surgical Anæsthesia, 1916.
Fagge's Pocket Anatomy, 1908.
Osler's Medicine, 1912.
Wheeler & Jack's Medicine, 1916.
Bennett's Pharmacy, 1915.
Mills & Humphrey's Surgery for Dentals, 1913.
Bourne's Synopsis of Midwifery, 1913.
Tweedy & Wrench's Pract. Obstetrics, 1908.
Warren's Surgery I., 1915.
Johnston's Midwifery, 1915.
Younger's Insanity, 1910.
Savage's Insanity, 1907.
Tubby's Deformities I., 1912. (2 vols.)

Guy's War Memorial Fund.

	£	s.	d.
Brought forward ...	3,824	6	4
Air, S. H. C.	2	2	0
Carter, A. H.	3	3	0
Gwyn-Davies, W. L.	3	3	0
Thomas, J. D.	3	3	0
Bently, Richard J.	1	1	0
Laver, C. H.	1	1	0
Thomas, T. P.	5	5	0
Aikin, Edmund	10	10	0
Milligan, R. A.	2	2	0
Cobb, W. E. Stanley	2	2	0
Lindsay, W. J.	2	2	0
Osborn, A. G.	2	2	0
Grace, W. H.	5	5	0
Jaynes, Victor A.	5	5	0
Ward, J. A.	3	3	0
Armstrong, R. Stowe	1	1	0
Hugill, G. F.	1	1	0
Fawsitt, Thos.	1	1	0
Wacher, Frank	2	2	0
Wacher, H.	2	2	0
Wacher, H. Stewart	2	2	0
Colclough, W. Frank	5	5	0
Medlock, C. H.	5	5	0
Conybeare, J. J.	5	5	0
Billing, E.	1	1	0
Wolfe, E.	1	1	0
Rowland, F. W.	10	0	0
Marshall, R. P.	2	2	0
Claxton, E. J.	2	10	0
Anderton, J. E.	2	2	0
Larkin, F. G.	1	1	0
Davies-Colley, H.	10	10	0
Key, M. Aston	3	3	0
	£3,934	9	4

Capt. W. Kelsey Fry's contribution was *not* an instalment, as reported in the last issue of the *Gazette*.

An Analysis of 8,670 Ophthalmic Cases Treated at a Home Hospital

BEING

A Report on the Ophthalmic Work carried out at the 2nd London General Hospital, St. Mark's College, Chelsea from September, 1914, to the end of 1917.

BY BREVET-MAJOR A. W. ORMOND, R.A.M.C.T.

SUMMARY.

I. *Number of Cases in each Category.*

Category.		*Total.*
Out-Patients		5896
Men Blinded in the War		684
Enucleations of One Eye		436
Affections of the Cornea		276
Corneal Ulcer	205	
Corneal Opacities	35	
Interstitial Keratitis	36	
Cataracts		130
Affections of the Conjunctiva		200
Conjunctivitis	128	
Trachoma	39	
Blepharitis	33	
Affections due to Indirect Injury		266
Concussion Injuries	117	
Concussion Blindness	39	
Contusion Injuries	110	
Affections due to Direct Injury		163
Foreign Bodies in Globe and Orbit	116	
Perforating Wounds of Globe	31	
Injury to Orbit involving Acc. Sinuses	16	
Affections of the Uvea		177
Iritis	96	
Choroiditis	47	
Cyclitis	34	
Affections of Optic Nerve and Retina		62
Optic Nerve Atrophy	47	
Detachment of Retina	15	
Myopia, &c.		59
Myopia	54	
High degree of Astigmatism	5	
Vitreous Opacities, Intra-Ocular Hæmorrhage		109
Nystagmus		15
Lachrymal Obstruction		14
Strabismus		13
Injuries to Nerves		9
Glaucoma		4
Episcleritis		5
Neurasthenia		9
Affections due to Various Causes		11
Periostitis of Orbital Walls, Sinuses, &c.	3	
Syphilis, 1 Primary Chancre, 1 Tertiary	2	
Congenital Dislocation of Lenses	1	
Exophthalmic Goitre	1	
Burns	1	
Injury to Occipital Lobe	2	
Hemiplegia	1	
Plastic Operation		64
Unclassified (Papers not available)		68
Out-Patients		5896
In-Patients		2774
Total		8670

II. *Average Time in Hospital for each Category.*

Category.	*Average Time in Hospital per Patient.*
Enucleations of one Eye	39 days.
Corneal Ulcer	36 "
Interstitial Keratitis	41 "
Corneal Opacities	30 "
Cataracts	43 "
Conjunctivitis	29 "
Trachoma	27 "
Blepharitis	25 "
Concussion Injuries	38 "
Concussion Blindness	31 "
Contusion Injury	31 "
Foreign Body in Eye and Orbit	40 "
Perforating Wound	32 "
Injury to Orbit	57 "
Iritis	33 "
Choroiditis	40 "
Cyclitis	45 "
Optic Atrophy	33 "
Detachment of Retina	36 "
Myopia	20 "
Vitreous Opacities, &c	39 "
Nystagmus	18 "
Lachrymal Obstruction	33 "
Strasbismus	25 "
Nerve Injury	37 "
Glaucoma, &c.	27 "
Plastic Operation	59 "

Taking the total number of in-patients, of whom we had definite notes—irrespective of their different categories—the average length of stay in hospital for each man was 35 days.

OUT-PATIENTS.

The number of new cases seen in the Out-Patient Department between October, 1914, when this Department was first started, up to the end of 1917, was 5,896. This does not include second and subsequent attendances.

The Out-Patient Department has been used extensively by M.O.'s attached to camps, hospitals, labour centres, recruiting boards, and travelling medical boards in and around London. Men have attended from Epping Forest, Hertford, Mile End, Bethnal Green, Tooting, Mitcham, Springfield, Hampstead, Fulham, Dollis Hill, Richmond; from the large camps at Wimbledon and the White City; from the various labour centres in London, and from the Guards depôts at Purfleet, Windsor, and Reading.

Many other centres also, too numerous to mention, have asked and received opinions on

ophthalmic conditions occurring in soldiers under their command.

Owing to the fact that as early as 1914 the 2nd London General Hospital was constituted an ophthalmic centre where the men blinded in the war were to be sent, the hospital at Chelsea was referred to by large numbers of units, command depôts, hospitals, etc., for specialists' opinions on ophthalmic matters.

The numbers for each year have shown a very marked increase on the preceding year, and the numbers in 1918 are likely to be nearly equal to the preceding two years taken together.

The work of the department consists largely of testing the eyesight of men and recording their vision, working out their errors of refraction, ordering glasses if advisable, writing out reports for the M.O.'s sending the cases, fitting artificial glass eyes, treating small surgical or medical ailments, making ophthalmoscopic examinations, and, in 1917, discouraging malingerers.

In addition the 2nd London General Hospital is a spectacle centre for the distribution of glasses ordered elsewhere, but no account of such work appears in this report.

Number of New Cases seen at O.P.'s from October 7th, 1914, *to December* 31*st*, 1917.

Hypermetropia and Hypermetropic Astigmatism	1356
Myopia and Myopic Astigmatism	1814
Mixed Astigmatism	287
Presbyopia	115
Amblyopia in one eye	274
Strabismus	133
Enucleation	99
Nystagmus	31
Vitreous Opacities	41
Retinal Affections	56
Cataracts	122
Conjunctivitis, Lids and Lachrymal Affections...	241
Foreign Bodies on Cornia, Injuries, &c. ...	101
Corneal Ulcers, Opacities, &c.	229
Cyclitis	5
Iritis	43
Optic Nerve Affections	27
Choroidal Affections	76
Gas Cases	18
Inspections, Opinions, Records of Visions, &c., where no treatment or spectacles were considered advisable from a military standpoint...	828
	5896

IN-PATIENTS.

MEN BLINDED IN THE WAR.

Of the men who have been blinded during the war I have notes of 684, seen during the years 1914—17 inclusive.

Generally speaking, they may roughly be divided into two main classes :—

(1) Those who lost their sight owing to a transversely-passing missile, a bullet or piece of shrapnel, which entering on one side of the head passed horizontally or obliquely across and came in contact, directly or indirectly, with one or other orbits, passing out on the opposite side. The majority of these wounds were probably due to bullets, which in most cases passed clean across and did not remain in the tissues ; sometimes the bullet was subsequently removed, but not in the greater number of cases. Pieces of shrapnel, on the other hand, frequently remained in the tissues, owing, no doubt, to the fact that their irregular shape rendered them less able to overcome the resistance incurred.

(2) Cases in which, owing to the bursting of a shell, bomb, etc., in front of the face, the eyes themselves were either destroyed directly, or, pieces of metal penetrating them, they subsequently shrivelled up as the result of a chronic septic irido-cyclitis, engendered by the presence within the globe of innumerable minute metallic foreign bodies.

The proportion of bullet wounds, that is, "through and through" wounds, to those due to shell bursts is about 2 : 3, and the proportion has diminished during the last year, that is to say, there are fewer simple straightforward bullet wounds and more wounds due to bursting shells, etc. The reason for this is probably that given to me by Col. —— at the end of 1917, when I pointed out to him that we were receiving very few cases due to snipers' bullets compared with 1915 and 1916, "Ah, we have learnt how to deal with snipers now."

During the first three years of the war 659 men were transferred from the 2nd London General Hospital to St. Dunstan's Hostel. All these cases were wounded or lost their vision in 1914—17, and were for all practical purposes blind.

Of these, 340 were actually and really blind, that is to say, they had no sight at all; 175 of these had no eyes, both having been either destroyed by the injury or removed subsequently on account of panophthalmitis, pain, etc.; the remainder had either shrunken globes, severed optic nerves, or such extensive disorganization of the retina and choroid, etc., as to destroy sight entirely.

The majority of these St. Dunstan's cases were due either to "through and through" bullet wounds, sometimes called "entrance and exit" wounds, or to shell splinters driven against them by explosion.

The recorded numbers are :—

"Through and Through" cases...	...	140
Shrapnel and explosion injuries, &c.	...	248

In some cases the notes do not specifically state which was the cause.

A small number of blind cases, about 17, are the results of disease, such as optic atrophy, Leber's atrophy, detached retina, etc.

Amongst the men retaining some sight were one-eyed men with ruptures of the choroid, organised masses of blood in the vitreous, traumatic cataracts and traumatic irido-cyclitis with shrunken globes. Of these the happiest experience was that of the men who had traumatic cataracts, who by subsequent needling and evacuation of the lens material, got reading vision with proper glasses. If (and there have been about a dozen such cases) vision after the removal of the lens gave them 6/18 or better with correction, they were not kept at St. Dunstan's.

In some cases the fields of vision were good, damage having occurred to the macula only, and many men could "see to get about," but not having reading vision they were retained at St. Dunstan's for educational purposes.

Deliberate malingering was very rare indeed; a very few men took exaggerated views of their disabilities, and, owing to the increased pension for total loss of sight and the attractions of St. Dunstan's, were unduly influenced, perhaps, to acclaim themselves "blind," more so than would have been the case had there been no such amenities; they, however, were not, as a rule, very persistent.

It is impossible to record in this brief resumé of the Hospital work all the many interesting and instructive cases among these men, but those which illustrate some special point of interest will be related in a subsequent paper.

The cause of the loss of vision among all the 684 men under consideration here was either : concussion injury, resulting in rupture of choroid and retina, intra-ocular hæmorrhage, atrophy of ciliary body and shrinking, optic atrophy, sclerosing keratitis, traumatic cataracts, detachment of retina, or injury to occipital lobe; and sometimes two or more of these causes were operating.

ENUCLEATIONS.

Total number of cases of Enucleation ...	...	436
Number enucleated in England ...	76	
Number enucleated abroad ...	345	
Number no note where enucleated ...	15	
Number returned to duty	293	
Number sent to Auxiliary Hospitals	91	
Number discharged as permanently unfit	18	
Number of whose discharge there was no note	32	
Number died (Meningitis, 1; Peritonitis, 1)	2	

In this group are placed cases in which one eye was removed, the other retaining good vision.

The reasons for the enucleations are in their order of numerical importance :—

1. Gross injury at the time of the wound.
2. The presence of foreign particles in the eye.
3. Feared sympathetic inflammation.
4. Persistent pain.
5. Panophthalmitis.

Amongst the number are two cases in which the eye was removed on account of sarcoma of the ciliary body, two for staphylomata following corneal ulcer, and two for secondary glaucoma.

Only one case developed sympathetic ophthalmia, and he regained 6/9 vision in the sympathising eye.

The insertion of a glass ball in Tenon's capsule is recorded in 12 cases, and these were all successful in giving the patient an excellent stump for the carrying of an artificial glass eye.

AFFECTIONS OF THE CORNEA.

Total number of cases	...	276
Corneal Ulcer	205	
Corneal Opacities...	35	
Interstitial Keratitis	36	
Total number of cases of Corneal Ulcer	...	205
Number due to traumatism ...	85	
Number due to Non-traumatic Causes	100	
Number due to Malaria	8	
Number due to Dendritic Ulcers ...	11	
Number due to Gas	1	
Number returned to duty	127	
Number sent to Auxiliary Hospitals	61	
Number discharged as permanently unfit	7	
Number of whose discharge there was no note	10	

Causes why men were boarded as permanently unfit were, either that they were "one-eyed" men or both eyes were affected.

Corneal Ulcer.

There are 205 cases of corneal ulcer. Of these 85 were due to traumatism in some form, the majority the result of bomb explosions by which small fragments of metal, stone, mud, or grit were hurled against the eyes.

They were all of a superficial variety and resolved under the treatment ordinarily employed for corneal ulcers of a septic traumatic nature; some required actual cauterisation, either with the electric cautery or with pure carbolic.

This group does not include any in which perforation had taken place; those will be found among foreign bodies in the globe.

One hundred were non-traumatic. These include a large number of simple ulcers due to septic absorption, septic teeth being sometimes a cause.

Most were associated with similar conditions experienced during civilian life, which recurred during the stress of military life, and were no doubt the results of hardships and exposure on physiques which were not sufficiently robust to stand the strain.

The dendritic ulcers were an interesting group, and their association with malaria was definitely substantiated in some cases, but men coming from Salonika, Mesopotamia, and the East, and giving a history of malarial infection, were found to have ulcers which clinically showed no signs of being herpetic in form, and in some cases typical dendritic ulcers were found in men who had no history of malaria and had never been in the East.

The result of the treatment of these cases of corneal ulcer is very satisfactory from a military point of view. Only a very few were permanently discharged the Service, the vast majority being returned to duty, or to convalescent homes for continued treatment, and subsequently to duty.

Those discharged permanently were cases in which either both eyes were involved or where one eye had been removed previously.

Corneal Opacities.

Total number of cases of Corneal Opacity	...	35
Number returned to duty	28	
Number sent to Auxiliary Hospitals	2	
Number discharged as permanently unfit	5	
Traumatic	15	
Non-traumatic...	20	

These cases when admitted had healed corneal opacities. The traumatic ones were mainly the result of old accidents in childhood or early youth. A few had occurred as the result of war injuries, healed traumatic corneal ulcers, but the majority were non-traumatic, and the result of superficial keratitis due to ordinary septic causes such as are commonly found in any civilian out-patient department.

Interstitial Keratitis.

The majority of these were straightforward cases of congenital syphilis in men giving a definite positive Wassermann reaction.

The only point remarkable is that many were older than is usual, as interstitial keratitis is commoner before 20 and a large proportion of these men were over 20, and the onset of the keratitis was determined often by definite wounds to the eyes themselves.

Two cases were associated with malaria, one giving a positive Wassermann and one a negative; and two were associated with mustard gas, one giving a positive and one a negative Wassermann.

There were 36 cases of which :—

Number returned to duty	...	
Number sent to Auxiliary Hospitals ...	...	1
Number discharged as permanently unfit	...	1
Number of whose discharge there was no note	...	

CATARACTS.

Total number of cases of Cataract ...	...	13
Number due to Traumatism ...	118	
Number Non-traumatic in origin ...	12	
Number of Concussion Cataracts ...	19	
Number of cases operated on	41	
Number of cases where final result of vision was recorded	20	
Of these 14 obtained vision of 6/24 or better.		
Number of cases not operated on ...	89	
Of these 12 were Non-traumatic and 19 were Concussion (partial) Cataracts.		
Number returned to duty	53	
Number sent to Auxiliary Hospitals ...	35	
Number discharged as permanently unfit	25	
Number of whose discharge there was no note	17	

This category includes 130 cases of cataract affecting one or both eyes in men who still retain sufficient vision in either eye to prevent their being classified as blind men.

Of these 130 all are of traumatic origin except twelve, six of the twelve being lamellar cataracts of the type usually found in children

and young adults, and six of a senile progressive kind seen in the early stages.

Of the traumatic kind 19 were concussion cataracts due to contusions of the eye and mostly displaying the star-shaped opacity located at the posterior pole.

58 cases of traumatic cataract remained unoperated on as, for one reason or another, surgical interference seemed inadvisable.

41 were dealt with surgically, and of these, 20 have the final results recorded. In 21 cases, owing to their being sent to convalescent homes and being boarded from those centres, it has not been possible to obtain the final results, the patients having left the 2nd London General Hospital after being needled, but before the pupil was finally cleared of all opacity.

Of the 20 cases in which operative interference has been employed and the results recorded :—

14 have obtained good vision, *i.e.*, 6/24 or better with glasses;

6 have obtained less than 6/60.

AFFECTIONS OF THE CONJUNCTIVA.

Total number of cases		200
Conjunctivitis (simple)	78	
Conjunctivitis due to Gas	46	
Trachoma	39	
Blepharitis	33	
Pterygium	4	
Simple Conjunctivitis		78
Infective...	49	
Traumatic	22	
Accidental	7	
Gas Conjunctivitis		46
Without Corneal complication ...	40	
With Corneal complication ...	6	
Number of cases of Conjunctivitis including Pterygium (4)		128
Number returned to duty	79	
Number sent to Auxiliary Hospitals	40	
Number discharged as permanently unfit	3	
Number of whose discharge there was no note	6	
Number of cases of Trachoma		39
Number returned to duty	20	
Number sent to Auxiliary Hospitals	5	
Number discharged as permanently unfit	13	
Number of whose discharge there was no note	1	
Number of Cases of Blepharitis		33
Number returned to duty	24	
Number sent to Auxiliary Hospitals	5	
Number discharged as permanently unfit	3	
Number of whose discharge there was no note	1	

Blepharitis associated with errors of refraction or corneal opacities is responsible for a certain number of unfit men. Most of these were improved, but none permanently cured. The history was almost invariably a long one, and the condition was not obviously aggravated by military service. Probably the reverse was the case.

Conjunctivitis, etc.

The interest of this group lies in those cases of conjunctivitis due to gas. We received some very severe cases in which not only the eyes, but the skin of the abdomen, scrotum, penis, and buttocks was also very severely burnt.

Two cases had such severe injuries of the cornea that complete opacity of each resulted, and these two men were subsequently transferred to St. Dunstan's.

One instance of keratitis—the result of gas—was slight, and six of conjunctivitis, in which the cornea was also involved, were severe.

Where destruction of the cornea resulted, the cause was probably that the actual liquid had reached the corneal membrane, as these cases were the result of gas shells bursting close to the face.

In the early stages soothing treatment was employed such as hot fomentations, irrigations with normal saline and carbonate of soda lotions, boracic ointment, liquid paraffin, etc. After about a fortnight, however, more astringent treatment by sulphate of zinc, protargol, exposure to fresh air and light, was insisted on, and any case that remained in hospital more than a month was specially considered and reported on.

No cases were re-admitted during this period, and special efforts were made to prevent these lapsing into cases of chronic photophobia with functional blindness, although we received two or three cases sent to us under the impression that they were fit cases to be transferred to St. Dunstan's.

(To be concluded.)

Reviews, etc.

The Early Diagnosis of Tubercle. By Clive Riviere, M.D., F.R.C.P. *(Oxford Medical Publications.)* Second Edition, 1919.

The second edition of Dr. Riviere's book contains much new and important matter. The most notable feature is the full recognition and description ac-

corded to hilus tuberculosis in the adult, the frequency of which condition has, the author thinks, increased as a result of the debilitating influence of the war. "It can hardly be surprising," he says "if the long hours, mental anxiety, scrapped meals, and often too conscientious rationing among war-workers, particularly of the educated class and female sex, should often reactivate the old slumbering foci of a childhood infection."

The book is divided into two parts, the first being concerned with apical phthisis and hilus tuberculosis in adults, the second with tuberculosis of the thoracic glands and hilus tuberculosis in children.

The first part begins with a short but comprehensive account of the modes of onset and the various symptoms of adult phthisis, and we are glad to note that, in discussing the significance of hæmoptysis, the author lays stress on bronchiectasis, with or without fibrosis of the lung, as a not uncommon source of bleeding, particularly in young people. The section on physical signs is one of the most important in the book, for, in spite of all other diagnostic methods, "the physical examination of the chest still remains the broad highway towards the diagnosis of pulmonary tuberculosis." But, since the value of such examination depends largely on the skill and experience of the physician, the student and practitioner may be diffident of trusting to his own powers, and somewhat appalled at the rather elaborate nature of the diagnostic signs described. Dr. Riviere entirely agrees with those who hold that percussion yields positive information sooner than auscultation in the early diagnosis of phthisis, and his arguments in favour of gentle percussion are beyond dispute. A full discussion is given of the author's "reflex bands of dulness," and of Krönig's and Goldscheider's methods of topographical percussion. As regards auscultation, Graucher's "respiration rule" is "the earliest auscultatory sign, and passes over into 'respiration saccadée,' or râles at a later stage."

The author is careful to point out the various conditions which may lead to an erroneous diagnosis of tuberculosis of the lungs, such as apical collapse, acute apical catarrh associated with coryza or influenzal infection, pulmonary œdema with mitral stenosis or nephritis, chronic bronchitis with collapse, and particularly bronchiectasis.

The account of hilus tuberculosis in the adult has already been referred to. This form of pulmonary tuberculosis is frequently overlooked, since, as the invasion begins at the roots from the peribronchial glands, an extensive involvement of the central portions of the lungs may occur before the process has become sufficiently superficial to evoke auscultatory signs. The importance of radiography in establishing the diagnosis of this condition is obvious enough. A useful table of the differences in the physical signs obtained in hilus tuberculosis and apical phthisis is given, and the chapter concludes with brief clinical accounts of four cases of the former type.

In his estimation of the value of special diagnostic tests, viz., X-rays and the tuberculin reactions—cutaneous, subcutaneous, and ophthalmic—Dr. Riviere's critical powers are seen to great advantage, as also in the chapters on the temperature in diagnosis, the tuberculo-opsonic determination, and the complement-fixation test. It is worthy of note that in his account of sputum examination, he considers the discovery of albumin as evidence of real value where the activity of old disease known to have been tubercular is in question, and where it has to be decided in an apical catarrh of doubtful causation, whether this is purely bronchitic or whether the parenchyma of the lung is also involved; a negative result is of far less value, since in early phthisis no real lung sputum may exist.

The second part of the book is as clearly written and as valuable in its subject matter as the first. The author agrees with Cornet in considering the so-called scrofulous stigmata, *e.g.*, dry, harsh skin, colourless hair, long eyelashes, and abundant downy body-hair, as due to chronic bacterial infection, and not necessarily as being pathognomonic of tubercle. Whether this view is correct or not, and it is difficult to substantiate, does not very much matter, since in practice, we believe, the presence of these stigmata may be considered as very strong evidence of an extensive tuberculous infection in early life, and we are inclined to the opinion that the chronic absorption of tuberculin is usually, if not always, responsible for the development of the physical characteristics of what has been termed the tubercular diathesis.

Enough has been said, we hope, to indicate the importance and value of Dr. Riviere's book. It is of convenient size, and contains reproductions of several excellent radiograms of the chest, which are particularly clear and instructive. We trust that it will be widely read, not only by practitioners, but by students and hospital residents still engaged in their work in the medical wards, for it should prove an admirable stimulus for the careful study of pulmonary tuberculosis, and of physical signs, both normal and abnormal.

Appointments.

R.A.M.C.

Capt. John Stevens, R.A.M.C.(D.) relinquishes his commission and retains the rank of Captain.

Temp. Lt. W. H. Trethowan to be Temp. Capt.

Officers relinquishing their commissions.—

Temp. Lt.-Col. W. Hind (Maj. and Bt. Lt.-Col. T.F. Res.), retains the rank of Lt.-Col.

Temp. Capts. A. E. Boycott, V. Glendinning, W. E Tanner, C. C. G. Gibson, H. A. Cutler, G. A. Ticehurst retain the rank of Capt.

Maj. A. F. Hurst retains the rank of Lt.-Col.

Capt. G. W. C. Hollist to be Major.

3rd South. Gen. Hosp.—Capts. H. M. Clarke and W. B. Secretan are restored to the establishment.

Capt. V. E. D. Bergh, R.A.MC.(D.) to be Inspecting Dental Surgeon, Aldershot Command and to be Major whilst so employed.

Maj. A. C. H. Gray, O.B.E., R.A.M.C., to be Asst. Director of Pathology at the War Office, and to be Temp. Lt.-Col. whilst so employed.

Maj. D. P. Watson relinquishes acting rank of Lt.-Col. on reposting.

Late Temp. Capts. to be Capts.—E. E. Frazer, F. Wheeler.

Capt. G. E. L. Simons is transferred from the Special Reserve to the Regular Army.

Civil.

Douglas Allen to be Chief Schools Medical Officer, Sunderland.

L. A. Parry, F.R.C.S., B.S. Lond., to be Surgeon to the Queen Alexandra's Hospital for Sick Children, Brighton.

Change of Address.

H. H. Khan, F.R.C.S. Edin., Raoramble Street, Hyderabad, Deccan, India.

T. B. Layton, M.S., F.R.C.S., 10, Welbeck Street, W.

Maj. J. F. Venables, R.A.M.C., 73, Addison Road, Kensington, W. 14.

V. F. Soothill, F.R.C.S., Emmanuel College, Cambridge.

G. A. Ticehurst, M.B., B.C., 54, London Road, St. Leonards.

A. H. Taymour, 7, Ahmed Bey, Said Street, Abbasieh, Cairo.

Capt. J. A. Berry, No. 2 N.Z. General Hospital, Walton-on-Thames.

A. H. Todd, M.S., F.R.C.S., 6, St. Thomas's Street, S.E. 1.

Charles J. Parke, Roselea, 12, Ceylon Road, Westcliff-on-Sea.

Capt. S. W. Coffin, R.A.M.C., Southside, Medway Close, Golders Green, N.W. 4.

Capt. H. N. Greaves, C.A.M.C., Sidney, Illinois, U.S.A.

Douglas Allen, c/o Lady Allen, Scotland House, Sunderland.

E. C. Hare, Cheshire County Asylum, Parkside, Manchester.

Capt. H. B. Wilkinson, Kirkside, Bilton, Harrogate, Yorks.

Maj. T. D. M. Stout, 238, The Terrace, Wellington, N.Z.

Capt. G. E. L. Simons, 1st Batt. Yorkshire Regt., c/o Base Postal Depôt, Bombay, India.

E. W. Goodall, Bartram Lodge, Fleet Road, Hampstead, N.W. 3.

Capt. J. J. C. Howe, R.A.M.C. (S.R.), 94, Deepdale Road, Preston.

D. A. Davies, The Woodlands, Gowerton, Glam., S. Wales.

R. W. Cushing, Capt. R.A.M.C. (T.F.), Eaton Hall, Chester.

Cricket.

GUY'S v. NEW STREATHAM.

Played at Honor Oak Park on June 28th. Won by 3 wickets. Scores :—

NEW STREATHAM.

A. S. Turney, lbw b Skeels	29
B. T. Cafferdy, b Shaw	22
H. S. Vanton, b Skeels	0
W. G. E. Swallow, st Brown, b Woolridge	47
A. E. Turney, st Brown, b Woolridge	10
J. Barnes, run out	3
—. Gough, lbw b Shaw	19
H. Barns, b Woolridge	4
N. Grapnell, not out	0
—. Straton, c Rose, b Shaw	0
Extras	5
Total	139

GUY'S.

G. D. Shaw, lbw b Swallow	40
F. C. Hunot, b Turney	32
T. Woolridge, b Swallow	8
A, L. MacKay, b Turney	6
S. Rose, b Turney	9
F. J. Biddle, b Turney	27
P. B. Skeels, b Turney	9
J. Van Geuns, run out	19
—. Eglington, b Turney	1
C. Vincent Brown, lbw b Turney	37
G. P. Lindsay, not out	0
Extras	17
Total	207

GUY'S v. HORTON WAR HOSPITAL.

Played at Epsom on July 2nd. From the start runs came easily, until the innings was declared at 269 for 8 wickets after 1¾ hours. The opponents could make little headway against Biddle's leg breaks, who took 6 for 41. Scores : —

GUY'S.

D. M. Whitcombe, c Fisher, b Lloyd	24
G. P. Lindsay, b Lloyd	42
G. Hunot, b Lloyd	14
C. Vincent Brown, run out	27
H. A. Harris, st Parker, b Lacey	44
F. J. Biddle, b Lacey	52
R. Van Geuns, lbw b Lloyd	6
S. Rose, not out	30
F. Payne, b Lacey	2
E. J. Crisp, not out	4
J. A. Wharton, did not bat.	
Extras	14
Total	269

HORTON.

H. G. Parker, run out	2
Gnr. Maynard, c Crisp, b Biddle	24
Lt. Fisher, c Hunot, b Biddle	14
Major Winlow. c Crisp, b Biddle	18
Major Barty King, lbw b Payne	3

Capt. Lloyd, b Payne	9
Major Robinson, b Biddle	8
Pte. Wood, c Hunot, b Biddle	5
Capt. Kidman, c Harris, b Hunot	2
Cpl. Lacey, not out	0
Rflm Lowe, st Crisp, b Biddle	0
Extras	5
Total ...	91

GUY'S v. BEDDINGTON.

Played at Honor Oak Park on July 5th. The wicket was very soft and the batsmen always on the defensive. Beddington batted first, making 161. The Guy's bowling was extremely good, and had it not been for six dropped catches Beddington would have been beaten. The game was undoubtedly lost by bad fielding. Scores:—

BEDDINGTON.

H. Hayler, c Whitcombe, b Woolridge	2
R. J. Laroche, b Muir Smith...	16
T. R. Hammond, c & b Shaw...	35
W. A. Windsor, c Shaw, b Muir Smith	8
F. O. Harrison, c Woolridge, b Shaw	15
G. H. Ashbury, b Shaw	17
T. P. Bothwell, c Whitcombe, b Biddle	4
L. E. Ross, c Whitcombe, b Biddle	19
N. Nicholson, not out	22
F. C. Potter Irwin, c & b Biddle	1
G. A. Windsor, c Biddle, b Shaw	25
Extras	7
Total ...	161

GUY'S.

C. Vincent Brown, lbw b Ashbury	5
G. D. Shaw, b Ashbury	12
T. Woolridge, c Windsor, b Bothwell	33
G. H. Muir Smith, b Harrison	5
S. Rose, st Windsor, b Harrison	0
G. P. Lindsay, b Windsor	8
D. M. Whitcombe, c & b Bothwell	10
L. B. Helder, b Bothwell	12
H. A. Harris, c Ashbury, b Bothwell	5
F. Biddle, b Windsor	3
E. J. Crisp, not out	3
Extras ...	2
	98

Lawn Tennis.

GUY'S v. BART.'S.

This match was played at Honor Oak Park on June 21st, and resulted in a win for Guy's by 5 matches to 4.

This may seem strange after our defeat on the Cup Tie by Bart.'s. At this second meeting, Bart's were not at full strength; their first pair, Urwick and Johnson, and also Orchard were not playing. We had practically the same team as at Winchmore Hill. With the exception of the plucky fight made against them by Daniel and Schlimmer, Kridge and Summers (Bart.'s) had it all their own way. They always had plenty in hand, and won all three matches.

The conditions were on the whole, good. The team did not give at all a convincing display. It can hardly be lack of practise at this stage of the season, but lack of match play is probably the trouble. Scores:—

Laver and Strawbaun lost to Kridge & Summers (Bart.'s), 2-6, 3-6; beat Douglas and McCall (Bart.'s), 4-6, 6-3, 6-2; beat Joule and Visick(Bart.'s), 9-7, 6-0.

Shaw and Krige lost to Krige and Summers (Bart 's), 4-6, 0-6; beat Douglas and McCall, 6-2, 6-4; beat Joule and Visick, 6-0, 6-1.

Daniel and Schlimmer lost to Krige and Summers (Bart.'s), 2-6, 6-4, 6-8; lost to Douglas and McCall, 6-4, 1-6, 6-8; beat Joule and Visick, 6-1, 6-1.

The 2nd VI. should have played St. Thomas's Hospital 2nd at Honor Oak Park on the 21st June. We were disappointed, however, by St. Thomas scratching in the morning, owing to the weather not looking promising—a great pity as the 2nd VI. have hardly played together at all.

GUY'S v. LONDON HOSPITAL.

The first round of the Junior Interhospital Cup was played at Honor Oak Park, June 25th, 1919. It resulted in an easy win for the hospital. Scores:—

SINGLES.—J. Totton (Guy's) beat Hutchinson, 6-4, 6-3; Sedgewick (Guy's) beat Maitland-Jones, 6-3, 6-0; Schlimmer (Guy's) beat Thomson, 6-1, 6-0; Grosse (Guy's) beat Clouston, 6-2, 6-3; T. A. Shaw (Guy's) beat Barnard, 6-1, 6-1; L. Lyne (Guy's) lost to Trayler, 3-6, 6-8.

DOUBLES.—Totton and Sedgwick (Guy's) beat Hutchinson and Maitland-Jones, 6-3, 6-2; beat Barnard and Clouston, 6-2, 6-1. Schlimmer and Lyne (Guy's) beat Thompson and Trayler, 6-0, 7-5; Grosse and T. A. Shaw (Guy's) beat Barnard and Clouston, 6-3, 5-7, 7-5.

So the hospital won by 9 matches to one, five matches being left unplayed.

The next tie in the semi-final is Guy's v. Middlesex Hospital II.

On Saturday, July 29th the first VI. played Dr. Hunt's VI. at Honor Oak Park. Resulted in a win for the Hospital by 6 matches to 3.

Dr. Hunt and his partner, L. Smillie, won all their matches.

Births.

VENABLES.—On April 19th, 1919, at Highweek, Newton Abbot, to Helen and John F. Venables, Maj. R.A.M.C., a son.

REYNOLDS.—On June 25th, at Woodslea, Bexley, Kent, the wife of A. J. Reynolds, of a son.

COLLINS.—On June 26th, at the White House, Yoxford, Suffolk, the wife of Dr. E. A. Collins, of a son.

Death.

GROUSE.—On June 20th, at his residence at Kenilworth, William Grouse, B.A. Oxon., M.R.C.S., L.R.C.P., aged 64 years.

ED.—G. B. D.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE flames of the Peace bon-fire having now been extinguished for nearly a week, and processions and "rags" having been at length brought to a satisfactory conclusion, we at Guy's, no less than the world in general, are gradually settling down once more into the normal. It will be a great change for those of us who did not know the hospital before 1914, and, we hope, a change will also be felt by those who were here before the war and have now once more resumed the pursuits of peace. For while we earnestly hope that the esprit de corps, the sporting outlook, and the cheery frivolity of pre-war days have returned never to depart, we equally trust that the old indifference to things that matter will never again rear its head in Guy's. And so we look forward to a new Guy's with all the virtues of the old, but without its vices.

ONE change dependent on the coming of Peace—and an important one so far as our material weal is concerned—is the fact that newly-qualified men will no longer automatically step into a house appointment. There will be considerable competition for these posts in future, and the majority must inevitably fail in being appointed. Therefore, we think that this is a most opportune moment for reminding readers of the agency under control of Mr. Winston, the Wills Librarian, the advertisements of which will be found in every issue of the GAZETTE. This agency is run entirely for Guy's men, and even a casual glance at the tempting offers it makes to recently qualified men will be sufficient to make one realise how helpful it will be to those who have no definite work to undertake. The matter has been mentioned before in these columns, but apparently there are still many who are not aware of its existence.

THE attention of all Guy's men, both past and present, is drawn to Mr. Steward's letter, which appears in the correspondence columns of this number. It will be seen that it has been decided to revive the Guy's Hospital Biennial Dinner, which will take place this year at the Connaught Rooms on October 28th. This most useful and, we believe, most enjoyable function has, of course, lapsed during the past five years of war; and we feel sure that all concerned will be extremely gratified to learn of its revival. This year it should prove to be an occasion of happy re-union of old friends who have not seen one another for probably the most trying five years of their lives, and it is hoped that all who can will make a special effort to be present.

Mr. Thomas Baillie Johnston, M.B., Ch.B. Edin., who, since 1914, has been Lecturer on Anatomy at University College, and who also has acted as Superintendent of Dissections to the Conjoint Board, has been appointed first incumbent to the University Chair of Anatomy tenable at Guy's Hospital. Professor Johnston is probably best known to students as the joint author of *Beesly and Johnston's Manual of Surgical Anatomy*. The Medical School are to be congratulated on having so eminent an anatomist as their first professor.

WE are pleased to see Mr. Curry back again in the Counting House, looking fit and well, after his unpleasant experience. We trust that he has completely recovered from the injuries that he sustained.

WE are pleased to see that Dr. Maurice Craig has been appointed Consulting Specialist in Psychological Medicine to the Ministry of Health.

MIRIAM WARD has at length come out of mourning for her brother John, and now appears resplendent, newly decked with verandahs, kitchens, cots, etc. New, young life is surging in her breast.

In the near future Dr. Cameron will commence "going round" the new ward, thus giving to the new generation of men in the wards opportunities which have been sorely needed by their seniors. Also, the Salomon Infant Welfare Centre will shortly be opened, but of this a worthier pen has written on another page.

WE call the attention of readers to the list of interesting cases in the wards published in this issue of the GAZETTE. It is proposed to publish such a list every fortnight, in order that men who have not the time to go round with the Registrars, Physicians, and Surgeons may, nevertheless, have an opportunity of utilising the splendid clinical material which passes through this Hospital. Also it is felt that when the Physical Society starts its meetings next session, less time will be wasted trying to find a free space on a patient's chest on which to put one's stethoscope, and more time will be given to the discussion afterwards if men have a chance of seeing the cases previously.

IT is not necessary for us to announce here that the Choral Society has re-awakened. To all those who were in the Park on Friday evening last sweet strains of harmony were wafted from the Nurses' Home, and occasionally a sound as of distant applause was audible by those within. The men, however, were rather thinly represented. The reason for this is not clear, as, judging from the sounds in the bath-rooms between the hours of 7.30 and 9.30 a.m., the College is full of good material. We hope that next Friday more basses and tenors will be present.

WE should like to take this opportunity of congratulating Mr. Winston, the Wills Librarian, on his appointment as Assistant Manager to "The Hospital Gazette," the official journal of the Incorporated Association of Hospital Officers. Contrary to rumour, this does not mean that Mr. Winston's smile will no longer lighten the gloom of the Library. This appointment will in no way affect his duties at Guy's. We wish him every success in his new post.

WE have just received a letter from Captain Reginald Growse, R.N., brother of the late Mr. William Growse, an old Guy's man. It

will be seen from the letter, which we publish, that Mr. Growse bequeathed to the hospital a case of amputating instruments which formerly belonged to Sir Aston Key. We are greatly indebted for the receipt of this interesting gift.

List of Interesting Cases in the Wards.

MEDICAL.

Esther 18.—? Tubercular meningitis.
" 27.—Still's disease.
" 28.—Cirrhosis (æt. 14).
Stephen 16.—Cerebral syphilis.
Mary 40.—Paralysis agitans.
" .—Jacksonian epilepsy.

SURGICAL.

Barnabas 15.—Carcinoma of larynx.
Ruth 28.—Secondary syphilis—irido-cyclitis.
Naaman 7.—Molluscum fibrosum.
Astley Cooper 2.—Fractured cervical spine—monoplegia.
Lydia (Cot A).—Deformity of jaw.

Honours.

O.B.E.

Surg.-Com. R. H. J. Browne, R.N., for valuable services as principal Medical Officer on the Staff of the Vice-Admiral commanding the battle cruiser force.

Croix de Guerre.

Capt. (Act. Lieut.-Col.) E. Phillips, M.C., R.A.M.C.

Papers by Guy's Men.

Capt. E. Huntley, R.A.M.C.: Two cases of acute perforated gastric ulcer: operation: recovery.—*B.M.J.*, July 12th, 1919.

P. P. Cole, M.B., B.Ch., F.R.C.S., and another: Radical cure of femoral hernia by the inguinal route.—*Ibid.*

A. Ralph Thompson, M.Ch, F.R.C.S.: The capacity of, and the pressure of fluid in, the urinary bladder.—*Journ. of Anat.*, April, 1919.

Lieut.-Col. A. F. Hurst, O.B.E., M.D.: War contractions, localised tetanus; reflex disorder, or tetanus.—*Brit. Journ. of Surg.*, April, 1919.

J. F. W. Silk, M.D., and F. E. Shipley, M.D.: Sudden death under an anæsthetic.—*B.M.J.*, July, 1919.

Obituary.

Capt. Norman Allen.

Killed in action, April 14th, 1918.

Norman Allen entered Guy's as a Dental Student in May, 1913. He passed his first examinations shortly after the outbreak of war. In September, 1914, he enlisted in the Artists' Rifles and proceeded to France a few months later. In May, 1915, he obtained a Commission

in the 2nd batt. Royal Warwick Regt., and was wounded in the Battle of Loos on September 28th. He was in England until the following September when he was again ordered to France, being at this time attached to the 14th batt.

He was promoted Captain in July, 1917. The 14th batt. was ordered to Italy in November, 1917, and remained there until March, 1918, when it was again sent to France to assist in stemming the German offensive of that period.

Capt. Allen fell while "gallantly rallying his men in an attack upon a German outpost" on April 14th, 1918.

An Analysis of 8,670 Ophthalmic Cases Treated at a Home Hospital

BEING

A Report on the Ophthalmic Work carried out at the 2nd London General Hospital, St. Mark's College, Chelsea from September, 1914, to the end of 1917.

BY BREVET-MAJOR A. W. ORMOND, R.A.M.C.T.

(*Continued.*)

INJUDIES TO THE GLOBE THE RESULT OF CONTUSION AND CONCUSSION.

Total number of cases		266
Wounds the result of Contusion ...	110	
Wounds the result of Concussion ...	117	
Concussion Blindness	39	
Contusion Wounds		110
Number returned to duty	52	
Number sent to Auxiliary Hospitals	22	
Number discharged as permanently unfit	3	
Number of whose discharge there was no note	32	
Number died	1	
Concussion Wounds		117
Number returned to duty	73	
Number sent to Auxiliary Hospitals	30	
Number discharged as permanently unfit	7	
Number of whose discharge there was no note	7	
Concussion Blindness		39
Number returned to duty	18	
Number sent to Auxiliary Hospitals	9	
Number discharged as permanently unfit	4	
Number of whose discharge there was no note	8	

Contusion Injuries.

The differentiation between wounds due to contusion and those due to concussion is difficult to maintain, and probably many cases ought to be transferred from one category to the other.

By concussion is implied a "shaking," and by contusion a "bruising." But obviously a bruising is capable of starting vibrations in the deep part of the globe and so becoming capable of producing a concussion injury.

Contusion, however, implies a direct contact, whereas concussion injuries may be due to vibrations conveyed from a distance.

Concussion Injuries.

Under this heading are grouped injuries done to the globe by indirect violence, causing rupture of the choroid, retina, iris, and lens capsule, and resulting in intra-ocular hæmorrhage, irido-dialysis, irregular pupil, and cataracts.

Intra-ocular hæmorrhage in some instances where it was slight failed to obscure the view of the fundus and disappeared rapidly by absorption. In others it appeared, on the contrary, to increase so that details of the fundus, which had been seen and recorded, became after a time entirely obliterated and the red reflex lost.

This may be due to one of two conditions—

(1) Either fresh hæmorrhage occurs some days or weeks after the injury, even when the patient has been kept in bed and at rest, or—

(2) A mass of hæmorrhage encapsuled and confined, as it were, to one part of the vitreous chamber, subsequently, owing possibly to a rupture of the membrane confining it, and a liquefying of the vitreous, becomes dispersed over the whole posterior chamber, thus obliterating the red reflex entirely. In some cases it was absorbed later on, and in others, owing to its size and density, became discoloured, organised, and changed into soft, snow-white masses, which later again shrank and drew away the retina, subsequently leading to detachment and a shrunken soft eye.

The most satisfactory way of dealing with these masses of blood has proved to be by mechanical means, *i.e.*, massage, and the time taken for the absorption of the blood varied from one to six months.

Another point of interest is the time which elapses after the injury, before the lens turns opaque. It may be only a few days, but I have had some cases in which the lens has remained clear for six months and then become opaque.

Ruptures confined to the retina and appearing ophthalmoscopically as "holes" at the macula are, of course, rare compared to the far commoner cases of rupture of the choroid, involving the retina as well, but commoner still are the ruptures of the choroid in which the retinal vessels can be seen to pass over the rupture undisturbed.

Concussion Blindness.

One of the principal ocular features of the war has been the number of cases of functional blindness due to the violent explosions caused by high explosive shells, bombs, hand-grenades, etc. These cases may or may not have sustained definite organic injuries, but the clinical symptoms characterising their functional nature are very clearly marked.

Usually the patient has been rendered unconscious by an explosion in his close vicinity, and on regaining consciousness he finds that he is unable to see. When examined he presents the following symptoms: The eyes are kept closed, the lids may be frequently "fluttered," or as one man stated, "he could not keep his eyes from twinkling." On attempting to open the lids the patient resists forcibly by means of his orbicularis; when this is overcome to a sufficient extent to see the globes, they are found to be rolled forcibly upwards, and the pupils are always kept covered by the lids; he has great difficulty in looking downwards, and complains of pain and photophobia, and shows marked fatigue as a result of the examination. In some cases I have noticed an acceleration of the pulse-rate and also perspiration. The photophobia is not, however, really influenced by light, as the condition does not diminish in very subdued illumination. These patients never move about as blind men would, they invariably avoid hurting themselves, but all the same they never relax, even if watched for weeks at a time, the groping action of people with extremely defective sight, and judged by every test they maintain this condition indefinitely, and are undoubtedly psychically blind; the pupils react normally, and the fundus shows no definite change. There is no difficulty in differentiating them from malingerers, as they pass through long periods of real mental distress and serious discomfort. These cases vary enormously in severity; some recover rapidly, others seem to go on indefinitely if not treated, or treated unsuccessfully. Any lack of recognition of the condition in the early stages enormously prejudices the prognosis.

AFFECTIONS DUE TO DIRECT INJURY.

Total number of cases		163
Foreign Body in Eye and Orbit ...	116	
Perforating Wound of Eye ...	31	
Injury to Orbit involving Accessory Sinuses	16	
Number of cases of Foreign Body		116
Number returned to duty	84	
Number sent to Auxiliary Hospitals	25	
Number discharged as permanently unfit	1	
Number of whose discharge there was no note	6	
Number of cases of Perforating Wound of the Eye		31
Number returned to duty	22	
Number sent to Auxiliary Hospitals	7	
Number discharged as permanently unfit	1	
Number of whose discharge there was no note	1	
Number of cases of Injury to Orbit		16
Number returned to duty	7	
Number sent to Auxiliary Hospitals	6	
Number of whose discharge there was no note	3	

Foreign Body in Eye and Orbit.

In this group of cases are instances where various foreign bodies, mainly of metallic origin, struck the globe and inflicted damage. The nature of the missile varied: splinters of shrapnel, lead, brass, iron (magnetic and non-magnetic), stones from the road, sand, wood, and bone.

Generally speaking, the small fragments which were stopped by the resistance of the cornea or sclera resulted in comparatively small permanent damage to vision, and most of the cases regained good vision (6/12 and 6/6) after a long period of acute conjunctivitis and keratitis with photophobia.

Where fragments were brought to rest in the anterior part of the eye in the anterior chamber or iris, good results were obtained, the vision ultimately averaging 6/36, 6/18.

Those, however, in which particles of metal of even small size penetrated deeply into the vitreous, retina, and choroid were usually responsible for severe damage, poor vision, and often entire loss of the eye.

Metallic fragments damaging the eye by striking the globe, without actually penetrating the tunic, and which came to rest in the orbital tissue, gave varying results, according to the size of the fragments and the tissues involved.

Where the optic nerve was actually torn across, complete blindness resulted, but often severe intra-ocular hæmorrhage, with solid detachment of the retina or traumatic cataract, would result from these non-perforating wounds.

Some pieces of metal undoubtedly traversed the globe, entering on one side and passing out again, and in these cases also severe damage to vision resulted.

A large number of eyes which were found to be tolerant of the presence of metallic or other foreign bodies were left alone, if the extraction of the particles by the magnet was found to be impracticable (the fragment not re-acting to magnetic force), or if the fragment was in such a position and of such a size that the removal would probably mean a loss of vision which would render the eye useless.

The results of the extraction of foreign bodies by the electro-magnet when they have penetrated deeply into the globe are disappointing, but we must remember always that the mere passage of the metal, the violence of the impact and the consequent hæmorrhage preclude the possibility of a good result apart from the necessary damage due to the extraction, however skilfully done. Also it must be remembered that the cases sent to us from France would only be, in all probability, those that had received severe damage, the slighter cases being treated in the Base Hospitals at Boulogne, Rouen, etc.

Perforating Wounds of the Eye.

Included under this heading are 31 cases, one eye only being involved; the majority had prolapse of the iris, and after iridectomy 17 obtained vision of 6/24 or more, while more than half had vision equal to or better than 6/60; the greater number were due to pieces of metal striking the eye with considerable violence.

These cases do not include those which had traumatic cataract. From the point of view of surgical interference they form a satisfactory group, as none of them were lost by septic inflammation and the majority retained useful vision, in spite of the severity of the original injury.

Injury to the Orbit involving the Accessory Sinuses.

This group is really a large one, but most of the cases are included in the "blind" category, as the "through and through" wounds perforating the orbits and nasal or other accessory sinuses often caused so much damage that the patient was rendered quite blind.

These 16 cases, however, received damage mainly to one side. The symptoms of involvement of the accessory sinuses are: bleeding from the nose, discharge of pus or mucopus from anterior nares or into the throat, anosmia, acute sinusitis with abscess formation and later persistent sinus formation, blocking of the nasal airways, supra-orbital pain, and pain about the orbits generally, with œdema of the lids.

It is, however, remarkable what extreme mischief can be done to the bones of the face and the sinuses, and the patient make no complaint at all: most of the symptoms develop late and the involvement of the ethmoidal and maxillary sinuses often produce symptoms months after the occurrence of the wound.

AFFECTIONS OF THE UVEA.

Total number of cases		177
Iritis	96	
Choroiditis	47	
Cyclitis	34	
Number of cases of Iritis		96
Number returned to duty	51	
Number sent to Auxiliary Hospitals	28	
Number discharged as permanently unfit	6	
Number of whose discharge there was no note	11	
Number of cases of Choroiditis		47
Number returned to duty	16	
Number sent to Auxiliary Hospitals	5	
Number discharged as permanently unfit	21	
Number of whose discharge there was no note	5	
Number of cases of Cyclitis		34
Number returned to duty	21	
Number sent to Auxiliary Hospitals	9	
Number of whose discharge there was no note	4	

Iritis.

As causes of iritis these cases represent: syphilis, acquired (12) and congenital (8); gonorrhœa (13); sepsis, mainly from the condition of the teeth and mouth generally (9); traumatism, the result of small, often minute, septic particles of dust, stone, or metal being driven into the cornea, and in some cases the anterior chamber (12); and malaria, in which the blood was at the time of examination teeming with the benign quartan parasites, and the Wassermann reaction was negative (1); tubercle (1).

There is no doubt that cold and damp precipitate an attack of inflammation in those who have some latent septic focus present about

them, and that an uncured prostatitis or urethritis is often the primary cause of recurrent attacks, which are claimed as being due to the cold and damp of the trenches. This was more specially remarked in the winter of 1915—16, and amongst the junior subalterns.

As is so often found, a certain number (40) of these cases seemed to occur spontaneously, and no septic or infected association could be found to couple with the inflammation of the iris.

Choroiditis.

Twenty of these cases are due to acquired or inherited syphilis. Others are associated with myopia of a high degree, traumatism, or oral sepsis, and in others no certain etiological factor could be ascertained.

Cyclitis.

The causes in this group are mainly three: traumatic, septic from teeth, syphilitic. The same three causes were responsible for most of the cases of iritis. A few, however, had more unusual etiological factors, such as malaria, dysentery, and trench fever.

It would be expected that metastatic cyclitis and iritis would occur in connection with extensive wounds with suppuration, but this has only occurred in a very few cases, and these few are not of absolute certainty.

AFFECTIONS OF THE OPTIC NERVE AND RETINA.

Total number of cases		62
Optic Nerve, Atrophy and Neuritis	47	
Detachment of Retina	15	
Number of cases of Optic Nerve, &c.		47
Number returned to duty	17	
Number sent to Auxiliary Hospitals	4	
Number discharged as permanently unfit	12	
Number of whose discharge there was no note	14	
Number of cases of Detachment of Retina ...		15
Number returned to duty	11	
Number sent to Auxiliary Hospitals	3	
Number of whose discharge there was no note	1	

Optic Atrophy.

Optic atrophy forms a large and varied class, and the cases found in our records illustrate very well the many different etiological factors that produce this condition.

It should be pointed out that the cases of optic atrophy due to *direct injury* are not included in this list, only those traumatic ones the result of *indirect damage* from blows on the nose, orbital margins, and bones of the face, where the nerve condition was the most marked result of the blow. Also, as optic atrophy generally involves both eyes, many cases of atrophy will be found among the blind men sent to St. Dunstan's, and are entered under that heading.

Syphilis, both inherited and acquired, claims over a third of the total number.

Of the cases of atrophy consequent on severe hæmorrhage, I have only seen one case, and that was not very convincing; this fact supports the contention that where optic atrophy has resulted from severe loss of blood the patient has some general constitutional factor which has caused a general debility, and that severe hæmorrhage as a result of warfare, in perfectly healthy men, does not seem to produce optic atrophy.

Malaria and quinine both figure as causes of optic atrophy, and the usual attenuation of the central retinal vessels was seen in most cases due to quinine.

The familiar type of atrophy occurring in young men and characterised by a central scotoma, often designated Leber's type, gave four instances, and lastly there are also included cases similar to those with which we were familiar before the war in our civilian out-patient work, of optic atrophy associated with no other symptoms discoverable at the time of examination. However, one patient of this class died 18 months later of G.P.I.

Detachment of the Retina.

These were either fluid, due to the presence of subretinal exudation, or solid, due to blood which in many cases had organised.

Trauma was not infrequent in the history, and myopia was the cause of two.

MYOPIA, ETC.

Total number of cases		59
Myopia	54	
High degree of Astigmatism ...	5	
Number of cases of Myopia		54
Number returned to duty ...	37	
Number sent to Auxiliary Hospitals	2	
Number discharged as permanently unfit	12	
Number of whose discharge there was no note	3	
Number of cases of high degree of Astigmatism		5
Number returned to duty	3	
Number sent to Auxiliary Hospitals	2	

Myopia.

High myopes and men with high degree of ametropia associated with defective visual acuity are included in this group.

The myopes frequently had patches of choroidal atrophy, and a large proportion were either discharged the service or put into very low categories.

These men were all received into the wards of the hospital, and are not included in those attending the Out-Patient Department; they were found to be unable to carry on their duties in France and elsewhere, and were returned for re-categorisation or permanent discharge.

INTRA-OCULAR HÆMORRHAGE, VITREOUS OPACITIES.

Total number of cases		109
Number returned to duty	66	
Number sent to Auxiliary Hospitals	36	
Numbers discharged as permanently unfit	1	
Number of whose discharge there was no note	6	

Of these 109 cases—

81 were due to injury from explosion, shrapnel fragments being violently driven against the eye, in some cases penetrating it.

17 were due to bullets passing close to the globe and rupturing the membrane by concussion vibrations.

4 were spontaneous, no cause being ascertained.

4 were due to accidents (barbed wire, wood, &c.).

3 were not recorded in sufficient detail to say if shell splinter or bullet was the cause.

26 had vision equal to or better than 6/60.

19 had a foreign body in the eye, or had had one removed.

This category comprises those patients in whom hæmorrhage within the eye was the main clinical feature when the case arrived in hospital. The time taken for the blood to absorb varies from one to six months, according to the amount present and the degree of damage done to the tissues. The result in most cases was that after the vitreous cleared, ruptures of the choroid and retina were found.

Some of the blood became organised and formed masses of snow-white tissue, often with bands stretching across the fundus in various directions, and sometimes resulting in detachment of the retina owing to shrinkage.

NYSTAGMUS.

Total number of cases		15
Number returned to duty	7	
Number sent to Auxiliary Hospitals	1	
Number discharged as permanently unfit	6	
Number of whose discharge there was no note	1	

Of nystagmus there were 15 cases, all either congenital or due to defects of vision acquired during early infancy. These men had all been employed in France, but failed to continue to be able to fulfil their military duties; they were either discharged the service as permanently unfit or kept for home service, and many could claim an aggravation of their symptoms owing military service.

A large number of men—similar in condition—were seen as out-patients and were dealt with before being sent abroad.

It is doubtful if men with nystagmus (if well marked and associated with considerable ametropia and defect of visual acuity) ought to be employed at all for active military service.

LACHRYMAL OBSTRUCTION.

Total number of cases		14
Number returned to duty	8	
Number sent to Auxiliary Hospitals	5	
Number of whose discharge there was no note	1	

A large number of cases in which the lachrymal canaliculi and ducts were damaged are to be found in other categories: for instance, among "Men Blinded in the War" and "Injury to the Orbit involving the Accessory Sinuses," but a certain number were isolated cases and these were usually treated by antiseptic drops, etc., for a time, and then if the condition still remained unsatisfactory the sacs were excised.

STRABISMUS.

Total number of cases		13
Number returned to duty	12	
Number of whose discharge there was no note	1	

All these cases except two were convergent concomitant squint. Two only were divergent. They were associated with astigmatism or amblyopia in one eye, and were usually sent by the military authorities for treatment.

NERVE INJURIES.

Total number of cases		9
Number returned to duty	4	
Number sent to Auxiliary Hospitals	4	
Number of whose discharge there was no note	1	

The number of cases is large in which the muscles, or the nerves supplying the muscles, are damaged; all the cranial nerves from the first to the eighth inclusive have been involved in patients who have been included in

various categories. A few cases, however, have occurred in which the most marked result has been due to the damage done to the nerves and the diplopia consequent on this the main symptom troubling the patient.

Three cases of congenital ptosis were operated on, one associated with jaw movements.

GLAUCOMA, EPISCLERITIS, NEURASTHENIA, AFFECTIONS DUE TO VARIOUS CAUSES.

Total number of cases		29
Number returned to duty	14	
Number sent to Auxiliary Hospitals	4	
Number discharged as permanently unfit	5	
Number of whose discharge there was no note	6	
Glaucoma	4	
Episcleritis	5	
Periostitis around Orbit	3	
Syphilis	2	
Congenital Dislocation of Lens ...	1	
Exophthalmic Goitre	1	
Neurasthenia	9	
Burns	1	
Injury to Occipital Lobe	2	
Hemiplegia	1	

PLASTIC OPERATION.

Total number of cases		64
Number returned to duty	37	
Number sent to Auxiliary Hospitals	21	
Number discharged as permanently unfit	2	
Number of whose discharge there was no note	4	

A large number of cases of deformities in which plastic operations were performed are included in other categories: for instance, St. Dunstan's men, etc.

These cases placed together here have not been included elsewhere, and were admitted for the purpose of having scars removed or deformities remedied by plastic surgery. They are, for the most part, intermediate in point of time, and by that I mean they were operated on, or were sent for operation, when the wounds had only just healed and were thus intermediate between the cases operated on within the first week and the late cases, which are dealt with twelve or eighteen months after being wounded.

It is impossible to deal with them individually in a mere statistical report such as this, but it may be said that most were improved by means of flaps with pedicles attached, and no great number were dealt with by grafts removed from distant parts of the body.

In most cases suppuration had taken place in the area operated on, and the early disturbance of healed tissues necessitated by the operation resulted in most of the cases healing by marginal granulations, with some septic discharge.

The number of failures were few, the pedicle being sufficient to sustain the vitality of the graft, and the high degree of health and fitness of the patients ensured a good blood-supply and a vigorous reaction and resistance to the invading organism.

In fact a justifiable criticism might be passed on the earlier efforts, viz., that the grafts were too small, and not enough boldness was displayed in removing large enough pieces of tissue for transference, with the result that months later the shrinking which took place caused some disappointment, as in the case of contracted sockets.

Sometimes a second operation was necessary owing to the contraction being so great that too small a glass eye was all the space would allow.

Ectropion, contracted sockets, torn lids, destroyed lids, damage to bridge of nose, the removal of adherent scars and the closing over of the holes leading into the nasal cavities and sinuses (the result of bullet wounds), were among the commoner cases sent for operative interference.

ACCIDENTS.

In going through the medical case-sheets of these 2,774 men the number of injuries due to *accidents* other than those directly attributable to enemy action seemed to be large, and it was thought to be of interest to tabulate these cases and record them.

The number of preventable accidents numbered 160. The premature bursting of bombs, cartridges, etc., thrown into the fire, accidents from "horse-play," wood-chopping, generally by incorrect tools (such as chopping wood with a pick-axe), kicks from a horse, the inspection and manipulation of metallic objects picked up casually on the battle-field, etc., caused the majority of these. One of the most tragic and at the same time most stupid accidents was the result of lighting a fire on the top of a box filled with unused hand grenades. Many of these accidents happened at home in the bombing schools and schools of instruction, but more were received from abroad. The percentage is higher than one would have expected.

In summarising this statistical report it must be pointed out that no mention has been made of a very important fact regarding the work of the department, viz., that cases having very slight ophthalmic interest, but very serious general surgical wounds, were habitually treated and nursed by the staff, owing to the army regulations that all ophthalmic cases were to be drafted to the ophthalmic wards. It therefore sometimes happened that, for instance, a man who had had an eye removed in France was placed in the ophthalmic wards even though he had a bad compound fracture of the thigh or arm, wounds of the chest or shoulder, and, had this not been so, the average time spent by each patient in the wards would undoubtedly have been considerably lower.

It cannot be maintained that the record is entirely complete, as no arrangements were made to facilitate the recording and categorising of the medical records from an ophthalmic point of view, and also many cases were transferred to the Colonial authorities, together with their medical case-sheets, before copies had been secured, although this only occurred, as a rule, when the rush of work was considerable; such cases as may have been missed, however, would not be of sufficient number to materially alter the record as typical of the material passing through a large military ophthalmic department.

Guy's War Memorial Fund.

	£	s.	d.
Brought forward ...	3,934	9	4
Munro, H. A.	2	2	0
Muriel, G. Bertram	5	5	0
Trethowan, W. H.	25	0	0
Roberts, C. S. Lane	5	0	0
Clowes, E. F.	2	2	0
Howell, J.	1	1	0
Wragg, E.	3	3	0
Carr, T. E. Ashdown	1	1	0
Long, H. O.	1	11	6
Pearce, Frank J.	21	0	0
Fremantle, F. E.	100	0	0
Rayner, A. E.	10	0	0
Layton, T. B.	10	10	0
Rowland, W. J.	10	10	0
Moon, R. O.	5	5	0
Pedley, T. F.	10	0	0
	£4,147	19	10

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Guy's Biennial Festival.

DEAR MR. EDITOR,—It has to-day been decided by the Committee to hold a Festival this year on Tuesday, the 28th of October, at the Connaught Rooms, and Dr. Lauriston Shaw has been elected Chairman. So far as I can gather from the records at my disposal, the Guy's Biennial Festival was first held in 1858, and thereafter regularly took place without a break until 1914, the last Festival having been held on July 3rd of that year. The lapse of five years caused by the war is thus the first that has occurred in the history of the Festival.

Full particulars will be sent to all early in September, but I take this, the earliest, opportunity of notifying your readers of the date of the Dinner, and I ask all to make a note of it at once, so that a record attendance may be ensured to commemorate in a fitting manner both the conclusion of Peace and the resumption of the Festival.—I am, Sir, yours sincerely,

F. J. STEWARD,
Hon. Secretary.

98, Portland Place, W. 1.
July 22nd, 1919.

DEAR SIR,—I regret to occupy your space further, but in Mr. Thompson's reply to my letter of June 19th he raises two points which he terms objections to the operation I have described for the removal of a tuberculous kidney and ureter which call for further comment.

First, he states that the retention of an undivided bridge of tissue "completely limits the upper incision at its lower extremity, and this is a great disadvantage in cases of extirpation of a tuberculous kidney." This is quite incorrect; free access can be obtained to the kidney by the usual incision, whilst, if more room is required, the incision can be carried upwards between the last rib and the erector spinæ and the outer border of the quadratus lumborum muscle divided. The tuberculous kidney is not often very enlarged, and in my series of cases I have had no difficulty in obtaining a free exposure of it.

Secondly, Mr. Thompson would imply that my procedure of tucking the separated kidney and ureter into the retroperitoneal space involves a severe risk of infection of the connective tissue. If Mr. Thompson will read my account of the operation he will realise that particular stress is made of the fact that the renal pelvis and ureter are completely separated from the vessels in the renal pedicle, and that the vessels alone are ligatured and divided. No tuberculous area is opened, and there can be little risk of infection of the connective tissue from the surface of the kidney, the capsule of which remains intact. In my operation the infected ureter is only divided at the last stage of the inguinal operation, when measures are taken to prevent infection, whereas in the operation described by Mr. Thompson the tuberculous ureter is divided at the commencement of the operation before even the kidney is separated—a measure which must increase the risk of infection during the subsequent manipulations of the operation, and which must therefore be a less sound surgical proceeding.—I am, Sir, yours faithfully,

R. H. JOCELYN SWAN.

75, Wimpole Street, W.C.
July 15th, 1919.

DEAR SIR,—My brother, the late Mr. William Growse, B.A. Oxon., M.R.C.S., L.R.C.P., of Dudley House, Kenilworth, who died on the 20th June, 1919, requested me at his death to forward to Guy's Hospital a case of amputating instruments which previously belonged to Sir Aston Key, and which Sir Aston presented to my father, the late Robert Growse, M.D. Lond., of Brentwood, Essex. My father was, I believe, dresser to Sir Aston at Guy's about 1851. My brother, to whom my father left this case of instruments, was also a Guy's man, and graduated about 1880. If you would kindly inform me whether you will accept this bequest, and if so, to whom I should forward the case, I shall have much pleasure in doing so.—I am, Sir, yours faithfully,

REGINALD R. GROWSE,
Capt. R.N.

Dudley House,
Kenilworth, Warwickshire.
30th June, 1919.

[The instruments referred to have been received and handed over to the Gordon Museum.—ED.]

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Communication from War Office.

The Temporary Commissions in the R.A.M.C.

The Dean has received the following communication from the War Office :—

The Director-General, Army Medical Service, presents his compliments to the Dean of the Medical Faculty, and has pleasure in inviting his attention to the enclosed memorandum of the terms and conditions under which Temporary Commissions in the Royal Army Medical Corps are being offered for a period of twelve months, for service with the Army of Occupation.

The Director-General believes that this offer will appeal to many recently-qualified medical men, and would be greatly obliged if the announcement could be brought to their special notice. He would be glad to receive from the Dean a list of names of those who may be desirous of offering themselves as candidates for such appointments and who can be recommended as likely to make efficient Officers of the Royal Army Medical Corps, and he will be happy to furnish any further information that may be desired, as well as forms of application for Commissions. The necessary medical examination as to candidates' fitness for appointment will be arranged to suit their individual convenience.

The War Office is prepared to accept the services of Medical Practitioners, including those who have already served, who are desirous of undertaking duty with the Army.

The terms of service are as follows :—

Candidates who have served before will be commissioned in their previous substantive rank; those who have not served will be commissioned as Lieutenants.

The period of engagement to be for one year or until no longer required, whichever shall first happen.

Pay to be at the rate of £550 a year, inclusive of all allowances except Travelling Allowance and Expenses when travelling on duty, and Rations, or the allowance in lieu.

Outfit and kit allowance will be issued to candidates who have not received them for previous service.

Demobilised Officers, whether Temporary, Special Reserve, or Territorial Force, are eligible to re-engage under these terms.

All candidates must be physically fit for General Service at home and abroad.

Applications should be addressed to the Secretary, War Office, Adastral House, London, E.C., 4.

Appointments.

Medical School Appointments

JULY–SEPTEMBER, 1919.

Dressers or Clerks in Special Departments:—

A. *Throats* (Mr. Mollison). — *Orthopædics.*—Messrs. L. Burvill-Holmes, M. Cohen, and H. T. Le Vieux.

B. *Throats* (Mr. Layton.)—*Genito-Urinary.*—Mr. M. A. R. Khalifa.

C. *Children—Eyes* (Mr. Eason).—Messrs W. Mark Brown, G. H. Oriel, C. M. Probert, B. M. Tonkin, and G. P. Lindsay.

D. *Skins—Nerves—Eyes* (Mr. Ormond).—Messrs. G. Massie, H. A. A. Pargeter, T. W. Turner and L. Moss.

Obstetric Dressers.—Messrs. H. A. Crowther, E. E. D. Gray, *T. Reed, J. Totton, and W. H. Turner (Mr. Bellingham-Smith); E. T. Lloyd, D. J. O'Meara, M. Sidky, and J. E. Wright (Mr. Chapple).

Surgeon's Dressers.—Messrs. J. J. F. Rooney, M. T. Ahmed, J. B. Gregor, F. L. Rayner, and L. R. A. Wells (Sir Alfred Fripp and Mr. Turner); D. Maximos, *M. Rose, F. Bekker, O. T. Maclaren, and A. H. Shelswell (Mr. Steward and Mr. Hughes); M. Maizels, E. F. Wilson, G. B. Kirkland, and L. K. Watson (Mr. Fagge and Mr. Davies-Colley); W. D. Doherty, S. Annecke, and G. W. Elkington (Mr. Rowlands and Mr. Bromley).

Medical Ward and Post-mortem Clerks.—Messrs. G. C. W. Curson, J. T. Jones, M. Hall, and J. Sullaiman (Dr. Fawcett and Dr. Cameron); J. H. Burn, G. E. W. Felce, P. L. Richardson, and W. S. R. Thomas (Dr. Beddard and Dr. Hunt); P. Couacaud, I. Rosenberg, and R. E. Williams (Dr. French and Dr. Poulton); I. W. Arnovitch, A. McKenzie, A. Mikhail, and W. H. Summerskill (Dr. Hurst and Dr. Mutch).

Messrs. H. T. Ahmed, H. O. Eksteen, R. J. Hodgkinson, H. B. Jones, B. Kessel, A. R. Patel, E. H. Richards, M. E. Shaw, C. M. Short, A. E. Strawbaun, H. W. Harvey, T. J. Lane and A. W. Hall.

Assistant Physicians' Clerks.—Mr. W. Remington (Dr. Mutch); F. W. Crook (Dr. Hunt).

Student Assistant in the Bacteriological Department.—Mr. B. M. Tonkin.

Student Demonstrator of Microscopical Pathology.—Mr. W. Mark Brown.

Pathological Assistants to the Demonstrators of Morbid Anatomy.—Messrs. †P. J. Briggs, †R. B. P. Lansdown, ‡S. Annecke, and ‡E. F. Wilson.

* July and August only.
† For three months.
‡ „ six „

R.N.M.S.

Surg.-Lieut. J. M. Bickerton to the *Royal Oak.*

R.A.M.C.

The following officers relinquish their commissions and retain the rank of Capt.:—Capts. F. W. Rolands and W. A. Easton.

Temp. Col. A. H. Tubby (Lieut.-Col. R.A.M.C., T.F.) relinquishes his temporary commission on reposting.

To be Capt.:—Temp. Capt. R. H. Lucas, Lieut. (Temp. Capt.) G. D. Gripper, late Temp. Capt. E. E. Frazer.

T.F.

Capt. (Act. Maj.) P. R. Bolus relinquishes acting rank on ceasing to be specially employed.

R.A.F.

Capt. (Act. Maj.) A. H. Todd is transferred to unemployed list.

Pass List.

Conjoint Board.

SECOND EXAMINATION—ANATOMY AND PHYSIOLOGY.

July, 1919.

C. A. Marais.	C. M. Short.
M. T. Ahmed.	H. W. Harvey.
A. W. Hall.	H. O. Eksteen.
E. Hardy.	R. J. Hodgkinson.
H. B. Jones.	B. L. Laver.
A. E. Strawbaun.	H. V. Croucher.

Change of Address.

Capt. O. St. L. Campion, R.A.M.C., c/o D.D.M.S., British Force, Vladivostock, Russia.

Capt. W. E. Watson, R.A.M.C., from 15, C.C.H., E.E.F., to 12, De Pary's Avenue, Bedford (Tel. 111), on demobilization.

Surg.-Com. R. H. Denny, R.N., R.N.H.S. *St. Margaret of Scotland,* c/o Admiralty.

R. Wynne Rouw, L.D.S., 6, Upper Wimpole Street, W. (Tel. Mayfair 1310).

Lieut. C. H. Kidner, R.A.M.C., Wellmarsh Military Hospital, Sheerness.

W. A. Easton, 1, Marlborough Road, Wimbledon Park, S.W. 19.

Edward M. Mahon, M.R.C.S., L.R.C.P., 45, Upper Brook Street, Park Lane, W. 1. (Tel. Gerrard 3147).

J. James, L.D.S., 4, St. Thomas's Street, S.E. 1.

V. Houchin, 45, High Street, Brentwood.

R. Sells, Cliff Lodge, Northfleet, Kent.

The Salomons' Centre.

THE Editor has asked me to write a note upon the new Salomons' Centre which it is hoped will be opened in September next. Twice before I have written short articles in the GAZETTE upon this subject. In the first I urged the need for a welfare centre for the mothers and babies of the Maternity Charity and made an appeal for funds; in the second I was able to annouce that the trustees of the late Mr. Leopold Salomons had given a sum of £10,000 towards the endowment of such a centre, to be called The Salomons' Centre, and that the Governors of the Hospital not only had promised a second £10,000, but had undertaken to provide a home for the centre in the near neighbourhood of the hospital. I am now able to put before your readers the completed plan.

The aims and objects of the Centre are to assist in every way possible the mothers and children of the Hospital Maternity Charity. In future the cards which entitle women to help in childbirth will be given out from the Centre, and at the same time the expectant mother will be examined by the Obstetric Registrar. Thereafter she will be visited in her home by Health Visitors attached to the Centre, who will assist her to make as complete preparation as possible for the reception of the baby. This antenatal work will be under the immediate supervision of Mr. Macnair. His new post of Obstetric Registrar and Tutor in addition gives him control of the whole Maternity Charity, and he will work as a sort of *liaison* officer between the Obstetric Department and the Children's Department with the Salomons' Centre. Mr. Macnair will have all the infants under his care, both on the District and in "Victoria," until their first appearance at the Centre.

It is not proposed to make any other change in the present arrangements of the Maternity Charity, and the service of Charities, Externs, and Pupil Midwives will remain unaltered.

The antenatal care and the midwifery service will be provided for the whole district. The post-natal work for the children from the first month of life until school age must necessarily be confined within much narrower limits. A small area situated in the immediate neighbourhood of the hospital has been mapped out, and it is proposed to concentrate attention upon the children born within its limits. Fortunately in our Maternity District there are already some ten other admirable welfare centres for post-natal work, some voluntary and some municipal, and with these we have been fortunate enough to enter into a working agreement.

Further, we are indebted to the Medical Officers of Health for Southwark and for Bermondsey for much assistance in this matter as well as for their interest and advice in the scheme generally.

The entire district has been mapped out into separate areas, approximately equal in size. Infants born within the central area around the Hospital will be sent to the Salomons' Centre, infants born in the rest of the District will be sent to the centre nearest their home. In this way no mother will be asked to take a long journey, and each centre will be responsible for the service of the network of streets in its immediate neighbourhood. If we are to give constant supervision to the children and help to the mother, if we are to undertake a study of the life of these children in their home environment, we must confine ourselves within comparatively narrow limits. Before the war some 3,000 babies were born yearly on the district. Probably a tenth of that number. will keep the Centre fully occupied. The homes of the mothers will be visited by the Health Visitors of the Salomons' Centre. Mothers and infants will attend the Centre at regular intervals, and records will be kept of the children's progress. Under the guidance of Mrs. Lauriston Shaw classes for simple cookery, for sewing and for mending, and short talks upon the health and management of the children will take place regularly at the Centre. It is not part of the scheme to include any form of treatment for mothers or infants who have developed definite illness. Such cases will be transferred to their private doctor or to the appropriate department of the Hospital. Below I print in facsimile a form which has been approved by all the infant centres in the district, which may be made use of to introduce children to the Hospital, and which it is hoped may help to lay all its resources at the disposal of those who are working in Infant Welfare in our neighbourhood.

GUY'S HOSPITAL.

TRANSFER SLIP FROM INFANT WELFARE CENTRE TO GUY'S HOSPITAL.

1. This slip, filled in over leaf, and enclosed in an envelope, should be sent with the child at the first visit to the Hospital.

2. Children may be sent direct to the following Departments of the Hospital and the envelope should be addressed accordingly :—

Department for Diseases of Children.
Department for Diseases of the Skin.
Department for Diseases of Throat and Ear.
Department for Diseases of the Eye.
Orthopædic Department.
Dental Department.

3. Cases requiring Massage, Remedial Exercises, Electrical Treatment, X-ray Examination, a Wassermann Test, Bacteriological Investigation, special Urinary Examination, &c., should be sent in the first instance to the Children's Department with the appropriate request.

4. The purpose for which the child is sent to the Hospital should be clearly stated over leaf, under the heading "Requirements," as for instance "For Diagnosis," "For Treatment," "For Wassermann Test," "For Massage," &c., &c.

.....WELFARE CENTRE.

Name..... *Age*.....

Address.....

Clinical Notes :

Requirements :

Date..... *Signed*.....

GUY'S HOSPITAL.

Department for Diseases of .....

This slip to be returned to Welfare Centre at conclusion of treatment.

Name.....

O. P. Number.....

Notes :

Date..... *Signed*.....

GUY'S HOSPITAL.

Department for Diseases of .....

This slip to be detached and sent back to Welfare Centre immediately, in cases where prolonged treatment is undertaken, when the diagnosis is of special interest.

Name.....

O. P. Number.....

Diagnosis :

Date..... *Signed*.....

HOURS OF ATTENDANCE.

Department for Diseases of Children, M., W., Fr., at 9,30 a.m.
Department for Diseases of Skin, T., 11.30 a.m.
Department for Diseases of Eye, M., Fr., 11.30 a.m.
Department for Diseases of Throat and Ear, T., W., Th., F., 11.30 a.m.
Orthopædic Department, M., W., 11.30 a.m.
Dental Department, M., T., W., Th., F., S., 9 a.m.

1. Members of the Hospital Staff are requested to return this letter to the Centre at the conclusion of Treatment, with a short statement of the case.

2. Where cases are sent for both Diagnosis and Treatment, Members of the Staff are requested to return the detachable slip with the Diagnosis, and to return the whole at the conclusion of Treatment.

The Staff of the Salomons' Centre will be as follows :—

The Obstetric Registrar and Tutor, Mr. Macnair.

The Medical Officer, Mr. S. Stewart Robertson.

Sister Superintendent, Miss Bertha Martin.

Secretary, Miss Hewer.

And Six Resident Health Visitors.

For myself I have planned a pleasant position with no special duties, but with an intense interest in the whole. I hope that we shall attract many workers to the centre, both graduates and under-graduates. I can conceive no more fruitful subjects for University Theses or Research of all sorts than those which will present themselves in this work. I hope that investigations of abortion and still births, of the failure to nurse at the breast, of malnutrition, of syphilis, of rickets, and of diarrhœa, to take but a few examples, may be undertaken in the Centre and in the laboratories of the Hospital. All the resources of the Centre will be at the disposal of workers to facilitate observations and records of all sorts.

Moreover, the Centre will be of direct educational value, in the first place, to the students in the Department for Diseases of Children, and, in the second place, to the Externs and the Pupil Midwives who will, I hope, take an important part in its conduct. Finally, it is hoped to make use of the Centre, in the near future, as a Training School for Workers in Infant Welfare who are studying for an approved Diploma in that subject.

An extreme sensitiveness to all faults of environment is characteristic of the little child. In the case of many of the children living around us, resistance to infection is dimin-

inished, and infections, of a severity hardly sufficient to disturb the well-being of the normal and healthy child, cause profound prostration and symptoms of great urgency. Such cases form a high percentage of the admissions to Hospital. If I had time I think I could show that they are not in reality cases suitable for Hospital admission at all. The mortality among them in all institutions is very high. The few cots which we reserve in the Hospital for Children in each year in the past have served as the death-beds for more than a hundred such cases. We hope that the efforts of those who work among the mothers and children in their own homes is proving a more efficacious means. The Children's Department will ultimately be completed by the provision of a ward, built specially for the purpose, containing about 50 cots. I believe that this will be ample for the service even of our enormous Out-Patient Department. Into it will go children suffering from the more acute and specific disorders, which call for special treatment only to be given in hospital. The studies of the common reactions to faults of environment will best take place in the Out-Patient Department and in the Salomons' Centre. It is by means of and through the mothers that alone we can hope to do permanent good.

Inter-Hospital Association Football Club.

A meeting of representatives from the several Hospitals was held at the London Hospital on Thursday, May 15th, at 4 o'clock. It was decided to re-start the Inter-Hospital Cup Matches next season. The opposing teams for first round were drawn thus :—

King's.—1st bye.—1. University College* v. London Hospital. 2. St. George's* v. St. Mary's. 3. Westminster v. St. Thomas's.* 4. Charing Cross* v. Bart.'s. 5. Guy's v. Middlesex.*

*Home team.

2nd round.—*a*. King's v. winner of 1. *b*. Winner of 2 v. winner of 3. *c*. Winner of 4 v. winner of 5.

Semi-final.—3rd round.—Winner of *a*, bye. Winner of *b* v. winner of *c* Semi-final.

Final.—4th round.—Bye of 3rd v. Winner of Semi-final.

Dates of Cup Matches are :—1st round, February 7th, 1920. 2nd round, February 21st. 3rd round, March 6th. Final match, March 20th.

Cricket.

GUY'S 2ND XI. v. CYPHERS 2ND XI.

Played at Beckenham, July 5th. Result—Guy's, 74 (R. C. May 19) ; Cyphers, 240.

GUY'S v. ST. MARY'S.

The semi-final of the Inter-Hospital Cricket Cup was played at Chiswick on Monday, June 30th. A very close game resulted in a victory for St. Mary's by 3 wickets. The result is a great disappointment after the form our side has shown ; but we lost the match through our indifferent fielding. Much more practice will be needed if the side is going to turn out to be a good one next year. Woolridge batted very well, and Biddle bowled with extremely bad luck, having several catches missed off him. Finally, we wish to congratulate St. Mary's on their plucky fight and well deserved victory. Scores :—

GUY'S.

G. D. Shaw, c Richards, b Date	26
G. Muir-Smith, b Roberts	14
T. Woolridge, run out	46
D. M. P. Whitcombe, c Lakkam, b Date	2
S. Rose, c Roberts, b Date	2
G. P. Lindsay, lbw, b Roberts	36
L. B. Helder, b Roberts	31
A. L. McKay, b Richards	5
H. A. Harris, not out	15
F. J. Biddle, b Roberts	7
P. B. Skeels, b Couch	1
Extras	16
Total	201

ST. MARY'S.

R. M. Handfield-Jones, c Whitcombe, b Biddle	37
R. V. Peton, b Muir-Smith	1
A. H. Richards, b Skeels	7
W. H. Date, b Biddle	2
E. T. Wright, b Skeels	0
F. H. Lakkam, c Shaw, b Muir-Smith	58
W. S. Roberts, not out	68
W. H. Browne, c Biddle, b Muir-Smith	6
E. J. Reeson, not out	23
R. Crouch, C. L. Mason } did not bat.	
Extras	10
Total	212

GUY'S v. KING'S COLLEGE SCHOOL.

Played at Wimbledon, June 25th. Guy's sent a comparatively weak side to Wimbledon, and won easily. McKay contributed a useful innings of 44, which included 8 fours. Curzon and Muir-Smith bowled well, the former taking 5 wickets for 26 and the latter 5 for 30. Scores :—

GUY'S.

L. B. Helder, b Pollard	10
H. A. Harris, run out	17
Muir-Smith, b Walter	15
A. L. McKay, st Seen, b Walter	44
G. P. Lindsay, c Dearden, b Rham	14
—. Eglington, b Pollard	8
G. C. Curzon, b Pollard	3
Van Geuns, b Pollard	6
W. F. Payne, c Rham, b Pollard	0
—. Bowen, b Rham	0
J. A. Wharton, not out	6
Extras	14
Total	137

KING'S COLLEGE SCHOOL.

Van der Borgh, b Muir-Smith	8
Sivers, b Muir-Smith	3
McNeil, run out	3
Walter, c Curzon, b Muir-Smith	15
Ahrens, b Curzon	0
Rham, b Curzon	7
Pollard, c van Geuns, b Muir-Smith	3
Webb, b Curzon	3
Dearden, b Muir-Smith	5
Tanner, c van Geuns, b Curzon	9
Seen, not out	1
Extras	12
Total	69

GUY'S v. THESPIDS.

Played at Honor Oak Park on Friday, July 18th, resulting in a draw. Owing to the Thespids arriving with twelve men, each team played twelve aside.

Guy's were weak in bowling, Biddle, Muir-Smith, and Skeels being absent. Rose and Harris gave the Hospital a good start, 65 runs being made before Harris was bowled. The fourth wicket fell at 115; Rose and Helder added 57 for the next wicket.

Rose's invaluable innings came to a close immediately after completing his first century for Guy's. His 101 was made out of a total of 174. His runs were obtained chiefly by cutting and hits to leg. He obtained 14 fours.

Helder, Thomas and Curson made useful scores.

The Thespids, who had 2¼ hours in which to obtain 237, started badly. Two wickets were down for 5 runs and six for 59. In dismissing Col. Fitzherbert, Thomas made a brilliant catch. At the fall of the ninth wicket there was still 25 minutes for play, but West and Egerton were able to play out time. West played a great innings for his side, besides taking five wickets. G. V. Rerner batted splendidly for his 38.

Notable features of the game were the improved fielding of the Guy's XI., the continued improvement of Rose, Helder and Harris in batting, and the good, all-round work of the substitutes. Wooldridge and Curson bowled steadily throughout.

GUY'S.

S. Rose, lbw, b West	101
H. A. Harris, b West	22
T. Wooldridge, c Humphreys, b Goodfellow	14
G. D. Shaw, b West	3
C. Vincent Brown, c Humphreys, b Rerner	7
L. B. Helder, b Hearne	23
R. Van Geuns, lbw, b West	2
G. W. Curson, b Hearne	19
J. D. S. Thomas, b Hearne	24
E. J. Crisp, not out	8
F. R. Payne, b West	0
W. Booth, st Scott, b Hearne	0
Extras	14
Total	237

THESPIDS.

A. S. Homewood, b Curson	4
Hartley Carrick, b Wooldridge	0
G. V. Rerner, c & b Wooldridge	38
Col. Fitzherbert, c Thomas, b Wooldridge	7
Dr. Hearn, c Curson, b Wooldridge	2
C. H. West, not out	51
A. W. Goodfellow, run out	0
Major Barber, c Van Geuns, b Curson	14
R. H. Scott, b Curson	22
C. Humphries, c Payne, b Shaw	7
B. Egerton, not out	21
Extras	7
Total (for 9 wickets)	173

D. E. R. Cowles, did not bat.

Guy's bowling:—Wooldridge, 4 for 59; Curson, 3 for 42; Shaw, 1 for 30; Vincent Brown, 0 for 26; W. T. Payne, 0 for 3; Helder, 0 for 6.

Births.

RICHARDS.—On July 6th, the wife of John Griffith Richards, Wellington Square, Hastings, of a son.

SELLS.—On July 2nd, 1919, at Westcliff-on-Sea, the wife of Roland Sells, M.R.C.S., L.R.C.P., of Cliff Lodge, Northfleet, Kent, of a son.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 811.] AUGUST 9, 1919. [SIXPENCE.

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Passim.

NEVER, perhaps, in the history of the dinners given by off-going Residents has been one so remarkable as the one which took place in the College Dining-room ten days ago. On that occasion, which will always be a happy memory to those who were fortunate enough to be present, Guy's Residents, past, present, and to come, met together in one great act of reunion. There were periods during the war when doubts arose as to whether the old spirit would ever come back again to the hospital; but those fears were most effectually settled by the proceedings of last Thursday week. Perhaps the most impressive moment of the evening was the toast, following Mr. Mullally's speech, drunk in silence, to the memory of Guy's men fallen in the war. Notable speeches were also made by Mr. Tanner who fully justified his reputation earned at former dinners, Dr. Ryle, Major Hancock, Mr. Victory, and the retiring and on-coming Presidents.

After dinner the company retired to the Smoking Room, where a most enjoyable evening was spent, the entertainment having some of the characteristics of a concert, a dance, and a water-polo match, although no one of them can be said to describe it accurately.

Mr. Whitcombe must be congratulated on the way he has performed his presidential duties during the last three months. He will be sorely missed both in the wards and in the field. We wish him and all the off-going Residents the very best of luck for the future. Also we take this opportunity of congratulating Mr. Mackay on his being elected President of the Residents. His election is an extremely popular one, as he is well known to a large number of Guy's men, past and present. He and the other Residents have our best wishes for success in their appointments.

OUR heartiest congratulations to Dr. J. A. Ryle on his obtaining the University Medal at the recent examination for the M.D. London. Also to Dr. G. E. Genge-Andrews who was also successful at the same examination.

A new edition of the Clubs' Union Year-Book will shortly be published. There has been no new edition since the outbreak of war, so that a good many alterations will have to be made. All secretaries are requested to forward any alterations in their respective sections to the Hon. Sec. of the Clubs' Union as soon as possible.

At a meeting of the Blues Committee on July 29th the following Blues were awarded:—

Cricket.—*Full Blues:* G. D. Shaw, T. Wooldridge, S. Rose. *Half-Blues:* L. B. Helder, P. B. Skeels.

Tennis.—*Half-Blue:* B. L. Laver.

Rugby Football.—*Full Blues:* F. W. Reitz, W. D. Doherty.

Association Football, Swimming, Athletics, Cross Country, Hockey, Boxing — *Nil.*

It was further resolved that those who win a Blue or Half-Blue can obtain the same only from Messrs. Lewin & Co. on production of a certificate signed by the Hon. Sec. of the particular Club.

It appears that the fact that the name of Sir Charters J. Symonds appeared in our Change of Address columns caused some to think that Sir Charters had retired. Needless to say, this is not the case, and we hope it will be a long time yet before the community is robbed of so energetic and skilful a worker.

We have to apologise for a slight error in last week's "Passim." While writing of the late Dr. W. Growse's bequeathal to the Mueum, we gave Mr. Aston Key the title of a Knight. His grandson, Mr. M. Aston Key, writes as follows:—"He was never knighted. He died of cholera in 1849, and in all probability the late Dr. W. Growse was one of his last dressers."

We take this opportunity of expressing the deepest sympathy of the whole Hospital towards Mr. C. P. Symonds on the tragic death of his wife.

The attention of our readers is called to a series of "Extracts from the letters of a Medical Student," which starts in this issue. Sir William Osler has very kindly sent these interesting letters. It will be remembered that Sir William sent us an account of one of Sir Astley Cooper's operations not long ago. These letters take us back to the days before Mr. Bob Sawyer and Mr. Benjamin Allen graced Guy's with their presence, and they confirm our opinion that those two gentlemen were not fair specimens of Guy's men at any time in the history of the Hospital.

List of Interesting Cases in the Wards.

MEDICAL.

Miriam 3.—Encephalitis lethargica.
" 4.—Acute anterior poliomyelitis.
Addison 2.—Miliary tuberculosis.
" 3.—?
" 5.—Mucoid ascites.
" 29.—Aneurism.
Esther 18.—Jacksonian epilepsy.
Stephen 49.—Purpura hæmorrhagica.

SURGICAL.

Dorcas 14.—Acute gastroenteritis. ?Peritonitis following exhibition of enormous doses of purgative.
Naaman 6.—Trigeminal neuralgia.
Barnabas 15.—Tracheotomy. Surgical emphysema.
Ruth (Cot A).—Ophthalmia neonatorum.
" 38.—Keratitis punctata.
Martha 1.—Epithelial odontome.
" 5.—Ulceration of rectum. ? Cause.

Change of Address.

Sister J. B. N. Paterson, c/o Friends' War Victims' Relief Fund, 91, Bishopsgate, E.C. 2.

G. T. Mullally, F.R.C.S., 4, St. Thomas's Street, S.E. 1. (Tel. Hop 2910.)

Fleet Surg. Marriott, R.N., R.N. Barracks, Devonport.

F. Cook, F.R.C.S., from Mesopotamian Exped. Force to Royal Societies Club, St. James's Street, S.W.

J. G. Gie, de la Haye, Wandel Street, Cape Town, S. Africa.

Major C. R. Nicholson, R.A.M.C., Rochford, Essex.

F. V. Bevan Brown, The College, Guy's Hospital, S.E. 1.

Lieut. G. F. Peters, R.A.M.C., Officers' Mess, Military Hospital, Cannock Chase, near Rugeley, Staffs.

Enlargement of the Abdomen in Children not due to Tubercular Peritonitis.

CLINICAL LECTURE BY DR. CAMERON.

Gentlemen,—It is sometimes a help to take a common symptom for which children may be brought to us and to consider the various conditions to which it may be due. The complaint of undue prominence and enlargement of the abdomen is a frequent one. Very often it must bring to our minds the fear that tuberculous peritonitis may be present. Tuberculous peritonitis is a condition which is a serious matter for the child, and because it is so serious we are right to bear the possibility constantly in mind. It is, no doubt, because of this cautious attitude that the diagnosis of tuberculous peritonitis is so often suggested in cases in which the further course shows that we have been needlessly alarmed. Let us consider other common causes of enlargement of the abdomen and try to find points of distinction from tubercular peritonitis.

The abdomen in infancy.—The abdomen of the normal child during the first year of life is relatively larger than in later life. The infant's chest is small and barrel-shaped. The transverse diameter scarcely exceeds the antero-posterior until the end of the first year. Until the child has walked, the pelvis remains undeveloped, and the bladder in infancy and early childhood may be rightly described as an abdominal organ. The infant's need for food is relatively much greater than in the adult, and, as a result, as is plain to see, digestive disturbances with flatulent distension of the abdomen are very common. It is well to remember that tuberculous peritonitis is a disease of great rarity during the first months of life. When it does occur in a young child of twelve or eighteen months the prognosis is more serious than in later childhood.

The tone of the muscles.—There is no more delicate index of a child's state of health than the tone of the muscles. At the time when very rapid changes are taking place in the whole skeleton under the stimulus of the newly-acquired power of walking, when the thorax and pelvis are expanding, when the spine is taking on characteristic curves and the legs are growing into efficient organs of support, a variety of agencies which are harmful to the child is capable of interfering with the processes of ossification and producing that softening of the bones which is called rickets. With the softened bones we find also lax and toneless muscles. The first indication that the ricketty child is improving is provided, as a rule, by an increase in muscular power and muscular tone. The muscle tissue is, as it were, more sensitive and more readily damaged than the bony. In very many cases the want of muscular tone is obvious, although ricketty changes in bone are absent. Nor is the muscular defect confined within strict age limits as in rickets. In children of all ages we may pass judgment on their development by paying attention to their muscular tone, their power of graceful, free movement, their stance and posture. The defects of muscular tone may be roughly estimated by a glance at the abdomen when the child is standing upright or sitting. A want of tone results in undue prominence of the abdomen.

In the third year of life the rounded form characteristic of the infant, with small chest, narrow pelvis, short limbs, and prominent abdomen, should have disappeared. The proportions of the several parts of the body should have become those of an adult in miniature. In rickets especially we find, because of the persisting narrow and often deformed chest and because of the ill-developed pelvis, a prominent,

flaccid, frog-like abdomen. Even when rachitic changes in the bones are not present, we often find a similar abdomen, but always as part of a general myatonia, which we can recognise elsewhere, for example, in the undue mobility of the joints and the too great flexibility of the limbs, the badly-supported and ill-braced spinal column and the winged scapulæ. The prominence of the abdomen is apt to be exaggerated because of a compensatory lordosis. As in cases of primary muscular atrophy or dystrophy the children whose muscles are ill-developed and toneless adopt in standing or walking the posture which brings the centre of gravity of the body directly above the base of their stance. The spine therefore shows an extreme lordosis by which the trunk is carried far backwards, while the shoulders again are rounded, with the head hanging forward.

I think that you will find in practice that the great majority of cases which come to you with the complaint that the abdomen is prominent are cases in which the explanation is to be found in this common, general muscular defect. Such children are commonly constipated. They suffer frequently from abdominal pain and discomfort due to dyspepsia. It is not surprising that the fear of tubercular peritonitis is often aroused. It is true the absence of a good muscular tone does not exclude the presence of tuberculosis. Nevertheless if the muscular system is clearly at fault, we are provided with an obvious explanation for the abdominal prominence and enlargement. Lastly, we may notice how the apparent enlargement of the abdomen tends to disappear when we examine the child lying upon his back. A prominence which disappears or diminishes quickly in this way is not likely to be due to tuberculous peritonitis. By recognising these muscular defects we account for by far the larger number of cases in which the complaint of enlarged abdomen is made.

Other varieties of peritonitis.—Even when we have decided that the enlargement of the abdomen is not merely due to the lack of muscular support and when the physical signs point to the presence of an inflammatory exudate in the peritoneal cavity, we must not always conclude that the condition is due to tuberculosis. In children, peritonitis, sometimes streptococcal, but much more often pneumococcal, is met with more frequently than is generally supposed. In little girls pneumococcal peritonitis is not rare. It is commonly confused with appendicitis, with tuberculous peritonitis of acute onset, or with typhoid fever. From appendicitis it may be distinguished by the evidence of the presence of a general septicæmia. The temperature rises suddenly to a much greater height. Delirium may be present from the beginning. Often there is diarrhœa, occasionally herpes labialis. As in pneumonia the skin may be very hot and dry. The abdomen is swollen and painful, very often tender in the right iliac fossa, and, as a rule, not so rigid as in appendicitis. If an operation is performed at once, the lower coils of the ileum and the vermiform appendix are usually found covered with thick, adherent, yellow lymph, but the appendix is not ulcerated, its mucous membrane is intact; it is not deeply congested nor gangrenous and contains no concretion.

It is, however, in the later stages of pneumococcal peritonitis that the confusion with tuberculous peritonitis is more likely to arise. In some cases of pneumococcal peritonitis the initial symptoms are less severe. They pass by with the explanation of colic, or a bad bilious attack. The child, however, continues ill with a prominent abdomen, in which the signs of fluid may possibly be demonstrated. The pus lies in the peritoneal cavity with something of the quiescence which we find also in

pneumococcal empyema in children. In such a case the diagnosis of tuberculous peritonitis is almost sure to be made. If the evidence of free fluid in the abdominal cavity is absent, many are then thought to have or to have had typhoid fever, and several of the cases which I can recall have come to me from fever hospitals. In either case it is common for the pus ultimately to point at the umbilicus. This in itself would not serve to distinguish the condition from one of tuberculous peritonitis. A distinguishing point is the suddenness with which pus may point at the umbilicus, and the relative absence of redness and induration at the umbilicus which precedes its outbreak. In three cases which I have met with, the pus had broken through unsuspected in this way and almost flooded the patient's bed. If there is any doubt as to the nature of the peritonitis, a leucocyte count should be of service. In pneumococcal peritonitis there is a high polymorphonuclear leucocytosis which is absent in tubercular peritonitis. The pus is generally without fæcal odour.

Other causes of enlarged abdomen:—

(a) Hirschprung's disease. Cengenital enlargement of the colon.

(b) Mucous disease or intestinal dyspepsia from carbohydrate excess.

(c) Coeliac disease.

I will not attempt in a short lecture to give a precise account of these three conditions, all of which are apt to be confused with tubercular peritonitis. A few of the points on which we rely for a differential diagnosis may be mentioned.

(a) With congenital enlargement of the colon there should be no confusion. The immense gaseous distension of the abdomen, the obstinate constipation which yields at times with the passage of enormous masses of fæcal matter and a corresponding decline in the abdominal enlargement, and the presence often of visible peristalsis should make the diagnosis clear. Even in minor degrees of dilatation the X-ray appearance after injection of an enema containing bismuth is characteristic.

(b) Under the name of mucous disease Dr. Eustace Smith described a group of symptoms which is very common and which certainly simulates tuberculous peritonitis very closely. Children with mucous disease are pale and wasted, and have a furred tongue and foul breath. The abdomen is often prominent and there is frequent complaint of pain. The temperature is apt to be irregularly raised. The bowels are irregular, constipation and diarrhœa alternating. It is characteristic of the disorder that the stools from time to time contain very large quantities of mucus.

As a rule the diet has contained an excessive amount of carbohydrate or starchy foods, and limitation of this excess may be followed almost at once by improvement. The children are almost always excitable, nervous and fretful, and the management of them by nurses and parents has often been injudicious.

It is clear that cases of this sort must be difficult to distinguish from cases of early abdominal tuberculosis. Nor is it easy to suggest points by which they may be distinguished. As a rule, when we are consulted in a case of this form of intestinal dyspepsia, the condition is of such long standing that its very chronicity makes the diagnosis of tuberculosis unlikely. There is generally wanting the definite onset, the history of previous health and vigour, which is common enough in tuberculosis. The presence of a great excess of mucus—and this is common, though not invariable—is an important point. So, too, is the nervous temperament

and the faulty management of the child, though, as always, we must beware of a two ready diagnosis of abdominal neurosis, with its fascinating capacity to fit all measures. In mucous disease we sometimes find that curious shifting catarrh of the tongue which we call the geographical tongue, and I have thought that attacks of urticaria papulata are more than usually common. I myself think that this so-called mucous disease is only a particular manifestation of a general catarrhal tendency. If the catarrhal tendency falls mainly not upon the lungs or skin, or nasopharynx, but upon the bowels, the interference with nutrition becomes more marked, appetite fails or becomes capricious, and the body becomes dehydrated. The aspect which is common to so many catarrhal children is, therefore, modified, but it may still be recognisable. Finally, the success of dietetic treatment by strict limitation of starches and sugars may make the diagnosis plain.

Coeliac disease.—Professor Still and others have described with very great clearness a disorder not, perhaps, very common, but clinically very well defined. You may remember that during the late time of dearth the possession of certain diseases entitled the holder to extra rations. Increased allowance of meat was confined to a very few diseases, but among the list appeared this disorder, coeliac disease, a name which puzzled a good many people. That will remind you of the most important symptom of the disorder—the inability to absorb fat. The children are pale and wasted, often with prominent abdomens, often with irregular rises of temperature, and always with a tendency to pass pale, greasy, often foul-smelling stools. The fat, though split and passed as fatty acid and soap, is not absorbed. Starches, too, are badly borne and increase the diarrhœa. A meagre diet, composed largely of meat juice, scraped meat and fowl, jelly, predigested starch in the shape of malted rusks, Mellin's foods, and so forth, is often all that can be tolerated for the time being. The disorder begins with some suddenness, generally in the second year, often in children who have thrived quite well to that point. It is not a disease of the very poor, or of ignorance and neglect. My worst case was one of a family of seven, the children of a farmer, and all save this one had had perfect and uninterrupted health. Herter has identified an organism which he believed to be pathognomonic. Again, the cases which I have seen have generally been thought to be cases of tuberculous peritonitis. The pale stools, which yet contain bile, are characteristic. The course is long and inveterate. Many recover, but some have died. Some have developed a very considerable degree of dropsy of the lower extremities. One of my cases, and it has been noticed by others, had purpura more than once, and finally had hemiplegia due apparently to a central hæmorrhage; œdema and purpura are also found in tuberculous peritonitis. Professor Still has noted a connection with scurvy. He thinks that some of the cases have followed upon infantile scurvy, and this apart from the tendency to suffer from scurvy which must follow if we restrict the diet so severely as often has to be done. The child with coeliac disease always looks much younger than its age. This infantilism is not found in the same degree with tubercular peritonitis.

If, when we meet with a case of enlarged abdomen in a child we have these very various conditions in mind, we shall, perhaps, be able to sift from among them more confidently those in which tuberculous peritonitis is certainly present.

Papers by Guy's Men.

E. G. Slesinger, F.R.C.S.: Surgical appliances.—*B.M.J.*, Aug. 2nd, 1919.

E. Billing, late Capt. R.A.M.C., and another: Kala-azar in Mesopotamia.—*B.M.J.*, July, 26th, 1919.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

SIR,—Permit me to express my sincere gratitude for your kind letter of the 29th, enclosing cheque for £130 9s. It is a source of great gratification to me to know that my dear husband was held in such high esteem by all who knew him at Guy's Hospital, and I shall greatly value the letters received from those gentlemen which you have so kindly promised to forward.

Again thanking you all for your great kindness, I remain, yours truly, FLORA BELL.

"Rest Cottage,"
Studland Road,
Elthorn Heights, W. 7.
July 30th, 1919.

SIR,—As I happened to be up at Guy's last Saturday night, I welcomed the opportunity of seeing the Peace bonfire advertised for 11 p.m. This I confidently expected to be the finest ever seen in the quadrangle, worthy of the great occasion, attended, according to tradition, by the Residents, and lit by the President himself.

What occurred was as follows. On my arrival at 11 p.m. I saw a few planks lying shamefacedly in front of the colonnade steps, and Thomas Guy gazing wistfully at some sand strewn in front of him. So perforce I too gazed (as did a lot of our Boro' friends) until 11.30, when, amid wild excitement, two or three bedraggled revellers garbed in what was no doubt, earlier in the evening, fancy dress, attacked the aforesaid planks and slowly but surely piled them on the sand. A quarter of an hour later another dozen or so equally bedraggled revellers appeared, fetched a few more pieces of wood, and at 12.10 knocked off work to view with pride a pile of wood quite 4ft. high.

Somewhere about this time somebody had a brain-wave and had the gates locked, but with half our Boro' friends on the wrong side, much to their surprise and delight.

At 12.15 the pile of wood was fired by an unseen hand, thanks to a gallon or two of oil, and to give it its due made a gallant, if ineffectual attempt to justify the name of bonfire.

A score of individuals then proceeded to join hands (they appeared quite surprised that they could not form a complete ring) and rushed gaily round the fire for two minutes, shouting out what I understood to be the chorus of a topical song very popular at Guy's last Christmas; after which they serenaded Sir Cooper Perry and Matron, and then (realising at last apparently the pitifulness of the proceedings) wisely retired and left the field open to the youth of the Boro', who made the most of their opportunity and took complete possession.

Thus did Guy's officially celebrate Peace, and such was the entertainment provided for the delectation of Thomas Guy. Yet he bore up bravely, and only once did I see him frown when following the direction of his gaze, I saw one reveller parading in and out of the crowd arm-in-arm with a lady friend—*not* a fellow-reveller clad in female attire. This no doubt was another of our delightful new customs, and in keeping with the occasion.—Yours, etc., E. S. BOWES.

North Lodge,
Tunbridge Wells.
24th July, 1919.

An Interesting Case for Diagnosis.

Mr. T., aged 55, married; no children. Chief engineer on C.P.R. boat.

Previous history.—Was in China thirty years ago. (Comment by one of the doctors: "That is equal to a diagnosis of syphilis.") Had malarial fever badly while in China. Slow nystagmus of the left eye has been noticed for the past six or seven years.

First seen by me May 17th, 1919. Patient lying in bed semi-comatose, but could be roused and answered questions in monosyllables, but quickly relapsed into semi-coma. Complains of headache and passes his hand over his head as if in pain. Temperature normal, pulse 80, respiration 17. Heart, lungs and urine all normal, spleen and liver not enlarged, no tenderness over abdomen and no spots. Pupils equal, normal, and react to light. No paralysis, reflexes normal.

May 19th.—Seen in consultation with Dr. R. L. Fraser. Above observations confirmed. Diagnosis, "Some syphilitic brain lesion." Advised to have blood examined on the theory of malaria, syphilis or typhoid. Also advised to have eyes examined by a specialist.

May 19th.—Examined by bacteriologist, Dr. W. P. Walker. Blood specimen showed no malaria and gave negative Wassermann and negative typhoid. No leucocytosis. Cerebro-spinal fluid was withdrawn and was under low pressure. It was faintly, very faintly, turbid, and centrifugalised deposit was sterile on culture. There were an increased number of polynuclear cells to lymphocytes as 18 to 1. Negative cerebro-spinal meningitis. Negative tubercular meningitis. Negative syphilis. Diagnosis by Dr. Walker by process of exclusion, cerebral influenza. Examination by eye specialist, Dr. Scott Moncrieff, no optic neuritis, no tubercle, no gumma.

History bearing on case given by assistant engineer:—

May 20th.—For the past three weeks the patient has complained of headache and has taken much bromo-seltzer. Patient struck his head about three weeks ago against an iron girder somewhat severely. He "saw stars," but was not unconscious and had no vomiting and made light of the blow. For the last five days on board, May 12th to 17th, he has felt ill, slept much, and has fallen asleep in his chair, which was most unusual for him. On the 12th he was shivering.

May 21st.—Patient continued in the above semi-comatose state till this date, when I found he had paralysis or paresis of the right arm and right leg, none of the face. Reflexes plantar and knee-jerk less on the right side. No hand grip. Umbilical, epigastric and cremasteric reflexes absent on right side. Temperature 98, respiration 17, pulse 48. Blood pressure 140. Diagnostic brain wave: "Patient has slow-growing cerebral tumour." In the afternoon, seen in consultation with Dr. C. Wace, the above observations were confirmed, and a diagnosis of cerebral tumour was made, but comment was passed—"Why no vomiting and why no optic neuritis?" We thought they would develop in time. Question of operation for decompression was discussed, but not advised. Dr. Wace carefully examined the head for injury, but found no bruise, no tenderness, and no œdema. Fracture of the skull was negatived.

May 22nd.—Patient more comatose. Paralysis right arm and right leg complete—none of the the face. Seen in consultation with Dr. H. E. Ridewood. Reflexes to-day, knee and plantar both exaggerated and equal on both sides. Dr. Ridewood examined the head carefully and found no signs of injury but drew attention to tortuous temporal arteries. He noted the blood pressure was only 140, but thought the case was one of slow cerebral hæmorrhage, and held out hope of recovery. He discussed question of operation for any other condition but negatived the idea.

May 23rd.—Patient less comatose. Pulse 66. Temperature 99·6. To-day I adopted the diagnosis of cerebral hæmorrhage.

May 25th.—Patient deeply comatose. Pulse 66. To-day I reverted to diagnosis of cerebral syphilis in spite of negative Wassermann, but held my tongue. The patient grew steadily worse and died on May 27th. I did not feel entirely justified in giving a death certificate of cerebral hæmorrhage, and in view of the conflicting opinions and the possibility of the slight injury to the head being at the bottom of the trouble, I refused to certify a cause of death unless a post-mortem of the head was allowed.

I would ask you to bear in mind that one of the chief difficulties in treating the case was due to the fact that at no time was the patient sufficiently conscious to be able to give any account of his illness or of his feelings. Again, the wife laid great stress on his history of old malaria which had been severe, and the first accounts of his illness commence with the patient shivering, but yet returning to work on his boat, but while under my observation he never had auything but a normal temperature until the final pneumonia set in. The blow on the head as a cause of illness was absolutely negatived by the assistant engineer and the wife, and apparently the patient never showed a bruise or tenderness, nor was he concussed and did not vomit.

A post-mortem was made of the head only the day after death. No fracture of skull found. Ethmoidal, sphenoidal and venous sinuses normal. Middle ears normal. Arteries at base very slightly thickened if at all. No meningitis—no congestion on surface of brain. No cerebro-spinal fluid in ventricles in visible quantity. No gumma or signs of syphilis. No cerebral tumour, but on section of the left frontal lobe an abscess equal in size to an apricot or slightly larger, was found, containing liquid and thick viscid pale green offensive pus contained within a recent hæmorrhagic wall.

Cause of death: Capillary hæmorrhage within the left frontal lobe subsequently forming an abscess, the cause of the hæmorrhage being injury from the blow on the head.

Victoria, British Columbia, June 4th, 1919.

A. B. HUDSON.

DEAR SIR,—Pruritus vulvæ is such a troublesome complaint, both to the patient who has to bear it and to the doctor who has to treat it, that I venture to mention such a case which had resisted all the usual lines of treatment until the patient was desperate for want of sleep. I then injected into the labia 3 c.c. of a 1 per cent. solution of urea and quinine hydrochloride with complete relief, which has now lasted for over three months.—I am, yours faithfully,

J. A. B. HAMMOND.

Appointments.

R.N.M.S.

H. L. Peregrine to be Surgeon, R.N.

E. Granger to be Surg. Lieut., R.N.

R.A.M.C.

Temp. Maj. A. F. Hurst relinquishes acting rank of Lieut.-Col. on ceasing to be specially employed.

Capt. R. Felton relinquishes his commission and is granted the rank of Major.

Capts. E. C. Myott and J. S. Bookless relinquish their commissions and retain the rank of Capt.

Civil.

Harry Lee, M.B., B.Ch., F.R.C.S., to be Honorary Ophthalmic Surgeon, Leeds General Infirmary.

Obituary.

Alan Chisolm Swinton Bell.

Alan Chisolm Swinton Bell came to Guy's in April, 1893, and commenced what proved to be a long and faithful period of service in the Pathological Department of Guy's Hospital and Medical School. For some years after the decease of Mr. Ware this department passed

through many vicissitudes, caused by frequent changes in permanent assistants, but with the advent of Bell it was destined to have a long period of efficient service. He was a man of retiring manner, a very good colleague and a thorough sportsman. One remembers how whole-heartedly he identified himself with the Old Officers and Servants' Cricket Club, and how he enjoyed the social side of the Officers and Servants' Dinner—a great annual event before the war.

He was quick and efficient at his work; what Bell said regarding pathological conditions was regarded as authoritative. His opinion was quoted frequently as a weighty argument at meetings of the Pupils' Physical Society.

His cheerful and kind disposition made him always ready to assist those who went to his department. Men studying Pathology owed much to Bell's specimens and slides. By an anecdote of the Demonstrator of Pathology who first examined these specimens, he could always impress the memory of his hearers.

Guy's mourns the loss of a popular and respected officer.

Guy's War Memorial Fund.

	£	s.	d.
Brought forward ...	4,147	19	10
Marshall, C. H.	2	2	0
May, W. Norman	2	2	0
Holman, H. J.	3	3	0
Holloway, S. F.	2	2	0
Elcum, D.	10	10	0
Morgan, E. M.	3	3	0
Ogilvie, W. H.	10	0	0
Pern, H.	5	5	0
Pryn, R. H. C.	2	0	0
Manfield, G. H. H.	5	5	0
Sawday, A. E.	3	3	0
Fleming, Robert	*50	0	0
Stewart, Charles J.	2	2	0
Malleson, H. C.	5	5	0
Kent, H. B.	10	10	0
Robinson, W. E.	5	5	0
	£4,269	16	10

*In addition to £100 contributed in December, 1918.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Guy's Hospital.

List of Appointments.

1919—1920.

Medical Registrar.—Mr. H. W. Barber.

Medical Assistant and Demonstrator of Physiology.—Mr. T. I. Bennett.

Assistant Ophthalmological Department.—Mr. J. S. Bookless.

Medical Assistant.—Mr. J. M. H. Campbell.

Assistant Anæsthetist (double duty) two afternoons a week.—Mr. S. W. Coffin.

Assistant Electrical and Actinotherapeutic Department and Surgical Assistant.—Mr. F. Cook.

Demonstrator of Chemistry (whole time).—Mr. J. O. Cutter.

Assistant to the Dermatologist in the Venereal Department and Medical Assistant.—Mr. E. Dennis Scott.

Surgical Assistant and Assistant Throat Department.—Mr. P. Dennis Scott.

Demonstrator of Pathology and Medical Assistant.—Mr. G. B. Dowling.

Surgical Registrar.—Mr. St. G. Gray.

Demonstrator of Chemistry.—Mr. A. Greeves.

Assistant Anæsthetist (double duty) two afternoons a week.—Mr. O. Halstead,

Medical Registrar.—Mr. T. B. Heaton.

Surgical Assistant and Demonstrator of Anatomy.—Mr. J. Joffe.

Assistant Neurological Department.—Mr. W. Johnson.

Demonstrator of Bacteriology (Junior).—Mr. S. Keith.

Demonstrator of Bacteriology (Senior).—Mr. F. A. Knott.

Midwifery Registrar (whole time).—Mr. A. J. McNair.

Officer in Tuberculosis Department and Demonstrator of Physiology.—Mr. G. Marshall.

Anæsthetist to Bright Ward.—Mr. A. D. Marston.

Gynæcological Assistant and Registrar.—Mr. C. H. Medlock.

Surgical Registrar and Assistant to the G.U. Surgeon in the Venereal Diseases Department.—Mr. G. T. Mullally.

Surgical Registrar and Demonstrator of Physiology.—Mr. C. E. Petley.

Demonstrator of Biology (and Anatomy for D. S.) (whole time).—Mr. T. Reed.

Medical Registrar and Assstant in Children's Department,—Mr. J. A. Ryle.

Assistant Ophthalmological Department.—Mr. C. M. Ryley.

Demonstrator of Anatomy and Surgical Assistant.—Mr. E. G. Slesinger.

Demonstrator of Pharmacology and Demonstrator of Public Health.—Mr. H. W. Southgate.

Medical Registrar and Demonstrator of Pathology.—Mr. C. P. Symonds.

Surgical Registrar and Demonstrator of Anatomy.—Mr. W. E. Tanner.

Orthopædic Registrar.—Mr. A. H. Todd.

Assistant to the Obstetric Surgeons in the Venereal Diseases Department.—Mrs. Vaughan.

Medical Officer in Bright Ward (Resident).—Mr. J. Victory.

Assistant in Throat Department.—Mr. A. M. Zamora.

Medical Registrars and Tutors.—Messrs. H. W. Barber, T. B. Heaton, J. A. Ryle, C. P. Symonds.

Surgical Registrars and Tutors.—Messrs. St. G. Gray, G. T. Mullally, C. E. Petley, W. E. Tanner.

Medical Assistants.—Messrs. T. I. Bennett, J. M. H. Campbell, E. Dennis Scott, G. B. Dowling.

Surgical Assistants.—Messrs. F. Cook, P. Dennis Scott, J. Joffe, E. G. Slesinger.

Gynæcological Assistant and Registrar—Mr. C. H. Medlock.

Midwifery Assistant and Registrar (whole time).—Mr. A. J. McNair.

Resident Medical Officer in Bright Ward.—Mr. J. Victory.

Officer in Tuberculosis Department.—Mr. G. Marshall.

Assistant in Neurological Department.—Mr. W. Johnson.

Assistant to Dermatologist in V.D. Department.—Mr. E. Dennis Scott.

Gynæcological Assistant in V.D. Department—Mrs. Vaughan.

Assistant in Children's Department.—Mr. J. A. Ryle.

Assistant in Electrical and Actinotherapeutic Department.—Mr. F. Cook.

Assistants in Throat Department.—Messrs. P. Dennis Scott, A. M. Zamora.

Orthopædic Registrar.—Mr. A. H. Todd.

Assistant to G.U. Surgeon in V.D. Department.—Mr. G. T. Mullally.

Assistants in Ophthalmological Department.—Messrs. J. S. Bookless, C. Meadows Ryley.

Anæsthetist to Bright Ward.—Mr. A. D. Marston.

Assistant Anæsthetists.—Messrs. S. W. Coffin, O. Halstead (double duty).

Demonstrators of Physiology.—Messrs. T. I. Bennett, G. Marshall, C. E. Petley.

Demonstrators of Pathology.—Messrs. G. B. Dowling, C. P. Symonds.

Senior Assistant and Demonstrator of Bacteriology (whole time).—Mr. F. A. Knott.

Junior Assistant and Demonstrator of Bacteriology.—Mr. S. Keith.

Demonstrator of Pharmacology.—Mr. H. W. Southgate.

Demonstrators of Anatomy.—Messrs. J. Joffe, E. G. Slesinger, W. E. Tanner.

Demonstrator of Public Health.—Mr. H. W. Southgate.

Demonstrator of Biology (whole time).—Mr. T. D. Reed.

Demonstrators of Chemistry.—Messrs. A. Greeves, J. O. Cutter.

OTHER APPOINTMENTS.

Anæsthetist to the Hospital (during pleasure).—Mr. A. D. Marston.

Poulton Research Fellow (two years).—Mr. J. M. H. Campbell.

July 25th, 1919.

From the Nurses' Side.

We are pleased to bring to the notice of our readers the gratifying fact that our Hospital Nursing Service had the honour of direct representation in the Peace Procession. Miss U. N. Kiddle, R.R.C., from the Middlesex Military Hospital, Napsbury, walked with the Sisters of the Civil Hospital Reserve. Sister Kiddle left "Clinical" August, 1914, to join the Q.A.I.M.N.S.

The other morning a "card" was brought to 10, St. Thomas's Street, with a Dockhead address. The bearer saying that the College Porter had sent him round as all the "Experts" were out.

Two nurses and their bags were spied by a friendly Boro' woman in a Hop Exchange tram and to their consternation she ejaculated loudly the pious wish:—"Please Gawd it will all be over before you get there!" A sentiment the nurses did not echo with schedules to fill and the thought of a journey to the top of Queen's Buildings in vain!

While awaiting the arrival of an addition to an already large family a mother was endeavouring to recall their number and other details. She gave up the effort somewhat wearily with the remark: "There, Nurse, I'm not sure, but the Lady up at Out-Patients' she rightly knows." C'est pour rire, but alas, that a card index can bear facts of birth and death that a life of poverty can erase from a mother's mind. S.

Leaves from a Medical Note Book (1914—1918).

I. A Simple Method of Administering Oxygen.

The futility of the old method of giving oxygen by means of a funnel or even with an improvised face-piece became apparent when gas casualties first filled the clearing stations.

The objections to the method are as follows:

1. The leakage of oxygen at the side of the funnel is so great that the actual increase in the percentage of oxygen inspired is insufficient to relieve the symptoms.

2. The patient has to hold the funnel himself or a special attendant is necessary.

3. A funnel or face-piece giving insufficient oxygenation merely worries and increases the mental and physical anxiety of the patient by limiting his sense of freedom to breathe.

4. In the case of œdema of the lung with profuse frothy expectoration a face-piece is wholly precluded and even a funnel is inconvenient.

5. One cylinder cannot conveniently be employed in supplying simultaneously more than one patient.

In other conditions producing oxygen-want encountered in civil practice the same objections hold. During the distressing aftermath of a bad chlorine-phosgene drift-gas attack, Capt. Adrian Stokes, D.S.O., R.A.M.C., suggested the following simple method, which was employed on that occasion and thereafter by the writer of these notes in all serious, frothy gas-cases; in the œdema of the lungs associated with trench nephritis; and in acute capillary bronchitis and other suffocative conditions;

while in one case of acute secondary anæmia due to hæmorrhage the anoxæmia appeared to be greatly relieved during the anxious phase.

A No. 8 soft rubber catheter, sterilised and lubricated with vaseline, is passed horizontally backwards along the floor of one nasal passage to a distance of 4 inches (in an adult), so that the end lies in the naso-pharynx. By means of a glass connection the supply-tube from the cylinder, emitting oxygen with a gentle hiss, is attached to the catheter. With the patient propped up, the supply tube, with a little "slack" to permit movement, is secured to the pillow with a safety-pin, while the catheter is looped along the side of the face by means of a strip of Mead's plaster.

All that is then necessary to do is to adjust the flow of the oxygen and to *keep it running*. By this means oxygen was given continuously for as much as 48 or 72 hours to patients admitted with grey-white cyanosis, rapid, failing pulse, and respiration rates as high as 50 and 60 per minute, recovery following as the œdema disappeared. A pinkish hue could be maintained and restlessness largely abolished in all but the moribund cases; there was free exit through the mouth and other nostril for the œdema fluid—an advantage which the otherwise more perfect Haldane apparatus does not secure; and fluids and nourishment could be administered without interrupting the flow of oxygen.

Lacking an oxygen chamber this is the simplest method, and though there is naturally some waste of oxygen in the expiratory phase it is not in practice extravagant. The regulation of the flow is greatly simplified by using the fine-adjustment fitting to the cylinder manufactured by Siebe, Gorman & Co. By means of improvised "distributors" several patients may be supplied from a single cylinder.

For cases in which intermittent administrations are enough it is better and less wasteful to use an ordinary N_2O bag giving pure oxygen.

Officers of the Clubs' Union Council for the Oncoming Year.

At a meeting of the Clubs' Union Council, held on Friday, the 18th July, the following officers for the coming year were elected :—

President : Sir William Hale White, K.B.E., M.D.

Chairman : F. J. Steward, Esq., M.S.

R. P. Rowlands, Esq., M.S., M.D.; H. C. Cameron, Esq., M.D.; A. D. Marston, Esq.; F. W. Crook, Esq.; W. D. Doherty, Esq.; the President of the Residents; the Editor of the *Guy's Hospital Gazette*; the Secretary of the Dental Society.

Treasurer : L. Bromley, M.Ch., F.R.C.S.

Secretary : J. A. Ryle, Esq., M.D.

Assistant Secretary : F. J. Biddle, Esq.

Auditors of Clubs' Union Accounts : Messrs. Chatteris, Nichols & Co., Chartered Accountants.

Auditors of Constituent Institutions Accounts : F. W Crook, Esq.; W. D. Doherty, Esq.

Guy's Hospital Clubs' Union.

The following Constituent Institutions of the Clubs' Union are at the present moment without officers and committees :—

Athletic Club.	Students' Club.
Debating Society.	Rifle Association.
Physical Society.	Football Association.

As it is most desirable that all these clubs should be re-organised as soon as possible, and as also the names of their officers are urgently required for the new edition of the Clubs' Union Year Book, the Hon. Sec. and Assistant Hon. Sec. of the Clubs' Union would be glad to meet any men willing to help in the formation of new committees, and if necessary to call a general meeting with a view to discussing the re-organization of the clubs named.

The non-affiliated Christian Union, the Physiological Society, and the Musical Society should also submit the names of their officers for publication in the Year Book.

(Signed) J. A. RYLE.
F. J. BIDDLE.

Extracts from the Letters of a London Medical Student.

My uncle, Edward Osler, the writer of these letters, had been apprenticed to James Trevooso, a Surgeon in Falmouth, from 1811, and at the conclusion of the apprenticeship went to London, as was usual, to walk the hospitals. His description of Sir Astley Cooper's Ligation of the Abdominal Aorta has already been published in the Gazette. A good account of the Borough Hospitals will be found in Wilkes and Bellamy's History of Guy's Hospital, and in the Story of the United Hospitals' Dining Club which perpetuates this old Association.

My uncle afterwards served for seven years as House Surgeon at the Swansea Infirmary, and practised for many years in Truro. Several interesting papers by him appeared in the Transactions of the Royal Society on Burrowing and Boring of Marine Animals, for a study of which he made a special trip to the West Indies, commemorated in a poem called "The Voyage," published in 1830. He also wrote "The Life of Lord Exmouth" (1835) and "Church and King." Several of his hymns—for which he is, perhaps, best remembered—are in the church hymn books.

William Osler.

London, June 14th, 1816.

. . . . A week ago I entered perpetual at Brookes. He shewed my father and myself his museum. Father fancied himself almost in Hades, &, such is the power of imagination, thought himself almost poisoned by the smell. On the second day of my attendance, I entered the dissecting room for the first time. The first object which met my view was the body of an old man stretched on a shutter in the court, the brains taken out, and the scalp hanging about his ears, while his straggling white locks were matted together by his blood. A hungry wolf was snarling at it, and straining to get at it as far as his chain would allow him. A tub full of human flesh was standing near it, some pieces of which I gave the eagles, who devoured it with avidity. On entering the room, the stink was most abominable. About 20 chaps were at work, carving limbs and bodies in all the stages of putrefaction, and of all colours; black, green, yellow, blue, while the pupils carved them apparently, with as much pleasure as they would carve their dinner. One was pouring Ol. Terebinth on his subject, and amused himself with striking with his scalpel at the maggots, as they issued from their retreats; here were five or six who had served but a three years' apprenticeship, most vehemently exclaiming against that regulation in the Apothecary's bill, which obliges every one to serve five years. Upstairs, nearly the same scenes were presented. In one corner was a subject, which had died of an extensive ulcer, and which was in such a state, that Mr. Brookes said that there were only the arms good for any thing, altho' it had only been brought in that morning. Recently finished preparations hung round the room, and on leaving it, even the air of London seemed pure.

(To be continued.)

Pass List.

University of London.

M.D. Examination.
July, 1919.

G. E. Genge-Andrews *J. A. Ryle

*University Medal.

Second Examination for Medical Degrees
(Part II.)

R. Brooke A. T. Rogers
G. W. Elkington A. H. Shelswell

Conjoint Board.

First Examination—Chemistry, Physics and Biology.
July, 1919.

**N. A. Arnold	‡H. C. Meathrel
†J. Dywien	‡F. M. Newnham
†M. M. El. Mishad	‡A. F. Percy
*G. T. Hankey	‡F. Widlake
**O. F. A. Krause	‡T. Wooldridge
*H. C. Lee	**A. Tom
E. N. C. Annis	**H. Slater
**P. B. Skeels	W. A. Caldwell
**E. G. Smallbone	*‡H. Evans
**D. S. Todd White	*R. A. Grant
*‡C. W. Greenway	O. G. Morris
*M. Hawke	‡R. G. Tame

**Chemistry and Physics only.
†Physics only.
*Chemistry only.
‡Biology only.

Practical Pharmacy.

J. G. Barrie. J. E. Wright. G. R. Aspinwall.

Final Examination.

July, 1919.

Medicine.

*T. Fernandez	H. N. Schapiro
W. A. Turner	W. J. McB. Allan
E. C. Grey	G. Packham
*C. H. St. John	S. T. Barrett
W. W. Payne	

Surgery.

*C. H. St. John	*H. M. Brown
*T. G. D. Bonar	G. A. A. Bradnack
*A. A. Osman	*A. Y. Massouda
*A. G. Ord	W. S. R. Thomas
*G. L. Cutts	*C. Moffat.

Midwifery.

E. C. Grey	M. Cohen
*C. H. St. John	H. T, Le Vieux
N. V. Wadsworth	L. Moss
B. M. Tonkin	

*Have now completed the examination,

Royal College of Surgeons.

L.D,S.—First Examination.

July, 1919.

J. H. D. Myott	J. Levy
†A. B. Daneel	*P. Domb
*R. Edwards	†A. Havenga
R. Hofmeyer	W. R. Hibbins
†I. Broude	G. C. Hughes
S. H. Rands	*D. J. Stofberg
O. F. Painter	J. A. Krige
†J. L. de Koch	†P. J. Walters
H. H. Pickett	†O. D'E. Morris
G, K. Jennings	*H. R. Ward
J. H. R, Creasy	†M. F. Braun
H. van Zyl	†W. A. Strickland
C. F. Hudson	

*Chemistry only. †Physics only.

University of Durham.

M.B., B.S.—Final Examination.

June, 1919.

H. L. Peregrine.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Food and the Public Health. By W. G. Savage, B.Sc. M.D. (Lond.), D.P.H. 155 pages and 8 plates. (Cassell and Co., Ltd.). Price 5s. net.

In this book the author, in language remarkably free from technicalities, has set forth the ways in which the public's food affects its health. Those odd chapters on this subject which we read in our text-books of physiology, medicine and public health are here found under one cover together with many fresh interesting facts all blended into one very readable whole.

The ways in which unadulterated food may undermine health are first dealt with briefly, special stress being laid on vegetarianism and vitamines. Chemical impurities are next considered, the author strongly condemning the unchecked use of chemical preservatives and "improvers."

The third chapter deals with the many paths by which bacteria can invade our food, and should cause the reader, as the author suggests, to acquire a violent prejudice in the favour of well-cooked foods.

Our beverages – alcohol, tea, etc.—are next dealt with in a very sympathetic manner. The fifth chapter on Milk is undoubtedly the most arresting in the book. The utter lack of cleanliness in the collection and distribution of much of our milk, the fact that from 13 to 70 per cent. of the cows in different herds are tuberculous and that over 3000 people yearly die from bovine tuberculosis, the large infant mortality directly due to contaminated milk—all these make an eloquent appeal in the author's hands for a vastly improved milk supply.

His remaining chapters deal with contamination of fresh meat, the dangers of inadequate supervision of the manufacture of prepared meat foods such as the sausage, the impurities in the adulteration of flour, and finally the relation of shell-fish to disease.

This book should undoubtedly be read by all who wish to take an intelligent interest in the reconstruction of our Public Health service.

Housing and the Public Health. By John Robertson, C.M.G., O.B.E., M.D., B.Sc., Medical Officer of Health of Birmingham. (Cassell & Co., Ltd.) 150 pages with 12 diagrams. 5s. net.

The author is to be congratulated on the masterly way in which he has handled so difficult and so vastly important a subject. The subject matter is clearly and simply expressed, and technical terms are avoided as far as

possible; at the same time the reader's interest is held, and there is no trace of tediousness in the book. This work will be full of interest to the great army of social workers that is growing up among the laity, but few will appreciate its worth so much as the practitioner and medical student.

Dr. Robertson, with his vast experience of Public Health work, has evidently been greatly impressed with the number of evils directly or indirectly attributable to bad housing: to quote from the introduction of his book—" . . . . bad housing is but one component of a vicious circle of which the other components are drink, poverty, vice, dirtiness, carelessness and ignorance. And bad housing, to change the metaphor, is the link of the chain which may most easily, and with the most permanent benefits be broken." In his first chapter the author points out the profound influence of housing on the health of the people, and adds statistics from five towns in England and Scotland, which are of a most convincing character. The structural requirements of a healthy dwelling are then very thoroughly dealt with, no essential being omitted, yet without a trace of "long-windedness." The environment and general requirements of the dwelling are next considered, and then follows a most interesting chapter on the future housing of the people, summarising the building schemes which have already been formed, and rich with valuable suggestions. The general block plan of the house is next considered, and in this, and in the following chapter on the accommodation of the cottage, the outlook is not simply utilitarian, but whenever compatible with cleanliness and health, the beauty of the home is strongly urged. Then follow chapters on Materials, Communal Services, Rural Cottages, Housing in London, the Reparation of Old Properties, Building of Houses in New Areas, and lastly an optimistic chapter on the Present Shortage and the Proposed Remedy.

As we have said above, one of the striking properties of the book is its clearness, and it should prove useful to those senior students who are about to take University examinations in Public Health.

Infant and Young Child Welfare. By Harold Scurfield M.D. (Cassell & Co., Ltd.) 5s.

This volume of the English Public Health series, contributed by the well-known Medical Officer of Health for Sheffield, deals in a popular way with the agencies now at work in this country to secure improvement in the health of infants and young children, and the difficulties with which they have to contend. The author lays all possible stress upon the important part which the mother plays in determining the future of the child, and his conclusion is that the test of all endeavours is whether they serve as aids to the mother or as mother substitutes, and that mother substitutes are not wanted. He marshals all the evidence which has led to the failure of most day nurses and crèches. He quotes from the Carnegie Report on Scottish Mothers and Children, that "A day nursery without the means of placing the children in the open air is one of the least desirable institutions." He deplores the present neglect of the study of children in medical education and urges that greater attention should be paid to it. The book is written for the general public, and it should fulfil very well its task of placing on record the aims and objects, the difficulties, and the achievements of the movement for Infant Welfare. It is brightly written, and nowhere too intricate or technical.

Cerebro-spinal Fever. By C. Worster-Drought, B.A., M.B., and Alex. Mills Kennedy, M.D. (The Edinburgh Medical Series, Messrs. A. & A. Black, Ld.) Price 30s.

To what extent there exists a demand for volumes devoting themselves wholly to the consideration of a single disease it is not easy to estimate. A study of the literature, though more laborious, and in the case of epidemic disease especially a perusal of contemporary articles in the medical press, as a rule, supply the better information. When, however, our knowledge of a particular malady has received numerous and valuable additions within a short period of years there is a more definite justification for the publication of a collective treatise. For such a treatise to be successful it must necessarily be based on a wide practical experience and not on academic inquiry alone. This stipulation the volume under review may be regarded as fulfilling, and the authors (one of them a Guy's man) are to be congratulated on the production of a book which is full and well-ordered and contains much sound observation and practical instruction. The book exemplifies that happy collaboration between the clinician and the laboratory worker which was one of the especial features of British war medicine. No aspect of the cerebro-spinal fever problem is left untouched; the important work in connection with the different types of meningococcus, now established, is carefully reviewed, the serum-therapy based on the recognition of these types is discussed, and the various techniques, diagnostic and therapeutic, are clearly described.

Those who have seen much of cerebro-spinal meningitis will readily agree with the authors that the "median perpendicular" method in lumbar puncture is both easier and more certain in its results. Their ability to dispense so largely with anæsthesia during lumbar puncture in meningitic cases is interesting and, perhaps, rather unusual. The importance—and the difficulties—of early clinical diagnosis receive special mention, and there is a good chapter on differential diagnosis. With regard to Kernig's sign the authors might well with advantage have elaborated

their description further. To lay so much stress on the angle of 45 degrees even as a rough dividing line between normal and abnormal, when both the subjective phenomena and the objective sensations of resistance found on eliciting the sign are so characteristic, suggests a failure on the part of the writers fully to appreciate the sign. The numerous references to the literature (the bibliography occupies eight pages) indicate that the authors have not neglected the work of other experts, while correctly basing their main conclusions on a very careful analysis of their own experiences. It is a curious omission that Ellis, whose name was attached to the therapeutic type-sera employed throughout the army in France, and who was there regarded as a leading authority, receives no mention.

The charts are clear and the illustrations good, and the recapitulations of essential points found at the end of certain chapters are useful. To anyone interested in the disease or engaged in the investigation of epidemics or in the treatment of individual cases the book cannot fail to be instructive.

Furthermore, as a summary of the whole work on cerebro-spinal fever during the war period it has an historic value, and together with Sir H. Rolleston's Lumleian lectures on experiences in the Navy, constitutes a record of enthusiastic and efficient research conducted between the years 1914 and 1919 in a most important field.

Cricket.

GUY'S v. ST. DUNSTAN'S MASTERS.

Played at Catford Bridge on Wednesday, July 9th, resulting in a win for Guy's by 80 runs.

GUY'S.

C. Vincent Brown, b Kempton	61
R. J. Laroche, b Locton	9
L. B. Helder, c & b Kempton	16
H. A. Harris, c Thorpe, b Kempton	20
K. M. Lindsay, b Locton...	16
G. P. Lindsay, c Dear, b Locton	20
J. A. Wharton, not out	16
A. L. Mackay, b Locton	0
G. W. Curson, b Locton	7
F. R. Payne, not out	2
Extras	10
Total (for 8 wickets) ...	177

E. J. Crisp did not bat.

ST. DUNSTAN'S MASTERS.

Gracey, c G. P. Lindsay, b Payne	9
Langford, b Laroche	21
Kempton, b Laroche	2
Dear, c Vincent Brown, b Payne	8
Thorpe, b Laroche	17
E. J. Smith, retired	0
Locton, b Wharton	15
Southwell, not out	19
Partridge, b Wharton	3
Stuart, b K. Lindsay	1
Young, c & b Wharton	0
Extras	2
Total	97

Guy's bowling :—Laroche, 3 for 39; Payne, 2 for 29; Wharton, 3 for 26; K. Lindsay, 1 for 1.

GUY'S v. R.A.F., UXBRIDGE.

Played at Honor Oak Park on Wednesday, July 16th, ending in a draw. Guy's, unfortunately, were weakly represented, Whitcombe, Wooldridge, Shaw, Skeels, and Lindsay being unable to play.

The R.A.F., one of the strongest teams we have met so far, batted first, and made 275 for 6, and then declared. Faircloth batted very well for his 119, and was well assisted by other members of the team.

Guy's had under two hours batting, and did very well in scoring 170 for 3 wickets. For this score Guy s was chiefly indebted to S. Rose, who played a very fine innings of 84. He was well assisted by Harris and Muir-Smith. The latter played very nicely on the off.

R.A.F.

Lieut. Hammond, c Payne, b Warton	25
Mr. Conyngham, b Biddle	10
Mr. Faircloth, c Crisp, b Vincent Brown	119
Lieut. Henwood, b F. R. Payne	49
Capt. Eliot, not out	25
Capt. Hoult, b Vincent Brown	16
Lieut. Dadley, c Vincent Brown, b Biddle ...	6
A. C. Filkins, not out	15
Extras	10
Total (for 6 wickets) ...	275

Messrs. Youens, Cobb and Hullcoop did not bat.

GUY'S.

S. Rose, b Faircloth	84
H. A. Harris, c Capt. Eliot, b Faircloth	31
E. H. Muir-Smith, c Capt. Holt, b Conyngham...	36
C. Vincent Brown, not out	7
J. A. Wharton, not out	9
Extras	3
Total (for 3 wickets) ...	170

J. D. S. Thomas, F. R. Payne, G. M. Stuart, W. F. Payne, F. J. Biddle and E. J. Crisp did not bat.

Guy's bowling:—Muir-Smith, 0 for 55; Biddle, 2 for 54; Payne, 1 for 48; Wharton, 1 for 30; W. F. Payne, 0 for 22; Stuart, 0 for 21; Brown, 2 for 35.

Death.

SYMONDS.—Suddenly, at Redhill, on July 23rd, as the result of a fall from a bicycle, Janet Mary Palmer Symonds, aged 26, the dear wife of C. P. Symonds and youngest daughter of Prof. Poulton, F.R.S.

Ed.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 812] AUGUST 23, 1919. [SIXPENCE.

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Passim.

THE recent spell of almost tropical weather has driven all who can be spared far from the Hospital. Those junior men, and those who are holding no definite appointment in the wards, have deserted us, and are, we trust, enjoying a well-earned rest in the company of Father Neptune. For those who remain, August must always be a trying time, but such an August as this, with the sun glaring from a cloudless sky, day after day, makes it all the more difficult to remain at work in the heat and vapours of Bermondsey.

IF, in an idle moment, one peruses the advertisement columns of any of our daily or weekly papers, one is struck by the appalling number of notices of patent medicines. The claims which the proprietors of some of these nostrums make are, in many ways, ludicrous, but at the same time they constitute an insult to the intelligence of the British public. Most of them only serve to demonstrate the profound ignorance of their authors. For instance, one good lady writes in an advertisement, which we will keep anonymous, that her mother suffered for thirty years from a functional (sic) nervous complaint, but that she was now better than she had been for years, and that it was all due to the medicine advertised. So far, so good; no one, we are sure, could quarrel with the fair correspondent's opinion, although we have grave doubts as to whether she had any idea of the true meaning of the word "functional." But the most ludicrous part of the whole thing is the advertiser's explanation of the action of his remedy. He explains that restoratives, not medicines, are what our kidneys need when they are weak, and that his remedies are restoratives. They nourish the kidneys through the kidney nerves, they nourish every nerve in the body, give strength, vigour and vitality to the entire system, and that is why they work such astonishing cures. It is then pointed out that this miraculous discovery is the recognised home remedy for no less than twelve different pathological conditions, ranging from sleeplessness to—infantile paralysis (!)

Similarly, there is a lot of unconscious humour in the letter of some dame who suffered for years from an ulcer on the leg, which was eventually cured by two bottles of a medicine, which, according to "Secret Remedies," consists almost entirely of iodide of potassium!

Surely it is time for this sort of thing to cease. In America a certain number of quack medicines are exposed in every issue of the Journal of the American Medical Association.

Might not something similar be done in this country? Why should there not be a campaign started in order to prevent the public being deceived? Notices could be placed in public places exposing the foolishness of the worst of the advertisements, and perhaps some of our sensational newspapers would publish articles on the subject. At any rate, something ought to be done, for while unfortunate dupes are trying to cure themselves with useless messes, valuable time is often lost, and sometimes the wretched patient is beyond the powers of medical or surgical aid before he consults a qualified medical man.

We publish in this issue a circular sent out by the Guy's Hospital War Memorial Committee. It will be seen from this that it has been decided to close the fund at the end of September. This, therefore, is a last appeal, and we hope that all Guy's men, past and present, who have not already done so, will forward some subscription, however small, to help to keep green the memory of those who gave their lives for them during the past five years.

The list of new appointments to be applied for in October, which is posted in the colonnade, makes it clear that the Reconstruction Committee has not been idle. From the point of view of the student, many of the changes will seem most satisfactory. The only criticism which we have to make is that the student himself has not been consulted at all in the matter of educational reconstruction. Surely the student, more than anyone else, knows exactly where and what are the difficulties in learning the rudiments of his profession. We should like to suggest, in all humility, that in future representatives of the students should be consulted in matters of educational reform.

We are pleased to hear that Sir Arbuthnot Lane has been appointed Senior Surgeon to the French Hospital.

We understand that it has been decided to hold the first post-war National Health Week in May, 1920. Previous to the war, the celebrations in connection with this week both in the metropolis and in the various local centres throughout the kingdom served to focus public opinion and sentiment on those aspects of personal and public hygiene which are more directly the province of the man in the street and the woman in the home than of the medical and sanitary authorities.

We think it is not making too great a claim to state that the pioneer work done by the Health Week Committee was one of many like factors in establishing the need for the newly-formed Ministry of Health.

It will be seen from the notice board in the colonnade that there are vacancies for two temporary Assistant Casualty Officers. During the war these appointments were very ably filled by unqualified men, who not only discharged their duties very satisfactorily, but also obtained a remarkable amount of knowledge from actual experience. We therefore strongly advise anyone who has passed some part of his final, and at present has no definite work on hand, to apply for one of these posts, in which he will not only be helping the Hospital, but also helping himself very considerably.

From the Surgery.

Sister (*to patient with letter*): "Did a doctor give you that?"

Patient: "No, Sister, it was guv me by a gen'leman."

Leaves from a Medical Note Book

(1914—1918).

II. A Case of Paratyphoid with Perforation.

Private N., — Dorsets, æt. 24, was admitted on the eighth day of disease as ? typhoid, with a history of fever and diarrhœa. One other case was admitted from the same unit. Patient was a fully inoculated subject against typhoid fever, but not against paratyphoid.

DIAGNOSIS.

A. *Clinical*—

Alimentary System.—Sordes; dry, furred tongue; abdomen full, giving "water-bottle" sensation on palpation; stools frequent, brown, watery.

Circulatory system.—Dicrotic pulse.

Respiratory system.—Bronchitis and bronchiolitis with slight hæmoptysis.

Excretory system.—Urine free from albumen, sugar, and diacetic acid.

Nervous system.—Dazed mental state; tremors of lips; pupils not dilated.

Skin.—Numerous "rose-spots" on abdomen; one on arm.

Spleen.—Easily palpable.

B. *Bacteriological*—

Blood Culture.—After prolonged culture (48 hours) gave paratyphoid "B" (blood taken 8—9th day of disease).

Urine culture.—Negative.

Fæces culture. — B. paratyphosus B. isolated.

Sputum culture.—B. paratyphosus B. isolated.

Agglutinations (1) Patient's serum (8-9th day of disease):—

	$\frac{1}{25}$	$\frac{1}{50}$	$\frac{1}{125}$	$\frac{1}{250}$
A.	—	—	—	—
B.	—	—	+	+
T.	+	+	+	+

(2) Patient's organisms against stock paratyphosus B. serum agglutinated up to 1/2000 dilution.

Progress of disease.—Patient's condition became gradually worse after admission, meteorism, incontinence of fæces and a very extensive bronchiolitis with some cyanosis of lips and ears being the most serious features. On the twelfth day of disease there was retention of urine, and for the next few days catheterisation was necessary.

TREATMENT.

1. *Nursing.*—After a few days the Fowler position was adopted as being most favourable for the pulmonary condition and to lessen the pressure of distended bowel on the diaphragm. Further, it was thought that, in the event of perforation, this would be the position most favourable for the localisation of peritonitis.

2. *Diet.*—Milk, porridge, custard, eggs, extra sugar (6—8 oz. per diem); biscuits and chocolate were also given, but patient was unable to take much of these. Fluids, "barley-water and lemon" ad lib.

3. *Symptomatic treatment.* — Pituitary extract ($\frac{1}{2}$ to $\frac{3}{4}$ c.c. hypodermically) was given p.r.n. to relieve meteorism, which it invariably did within a quarter of an hour of administration.

Further progress of disease.—On seventeenth day of illness, diarrhœa, which had abated for four days, became more profuse and frequent than ever, and a few blood shreds were noticed on one occasion. The return of diarrhœa suggested the probability of fresh ulceration.

At 6 a.m. on the morning of the nineteenth day of disease, although he did not volunteer a complaint of pain, the Sister observed abdominal tenderness on sponging and there was a fall of temperature to subnormal, with a rise within half an hour to 100°. At 11 a.m., although patient said he felt better than on the day before and the pulse was no more rapid or feeble than on previous occasions, and the abdominal distension only slightly worse, perforation was diagnosed on the following grounds:—

1. On palpation of the epigastrium there was a soft, inelastic sensation unlike that due to distended bowel, suggesting gas in the peritoneum. The patient's position in bed would have favoured the collection of gas in this region.

2. There was a wider extent of resonance on percussion, although the liver dulness had been

obliterated on former occasions by meteorism. There was, however, little or no dulness in the flanks.

3. There was tenderness on pressure, especially on the right side of the abdomen.

4. There was a limitation of abdominal respiratory movements best evidenced as follows: Previously on catheterisation, urine came away in a sluggish, continuous stream owing to general muscular flaccidity. On this occasion it came away in gushes synchronising with respiratory movements, suggesting that the flaccidity of the distended abdomen had been overcome by a rigidity too slight for the eye and hand otherwise to detect.

5. There was a cessation of cæcal gurgling.

6. There had been a temporary fall of temperature. Against the diagnosis of perforation were the patient's statement that he felt a little better, the absence of any marked change in the rate or character of the pulse, the absence of change in the facies, and a low leucocyte count (8,000 per c.m.).

Major Dickie, R.A.M.C., agreed with the diagnosis and the operation was performed by him without delay under chloroform anæsthesia (ether was not used on account of the severe bronchitis), saline being infused into the axillæ during and after the operation. An oblique incision was made in the right iliac region towards the flank, a large median incision being counterindicated by the meteorism; gas escaped from the peritoneum.

The peritoneal surface of the bowel was red and inflamed and covered with patches of thick lymph, more particularly over the cæcum and at the base of the appendix—which was removed. The perforation was not discovered. A counterincision was made above the pubes and drainage tubes inserted into both wounds.

Patient did well after the operation. There was no vomiting, and for two days no distension.

Urine and fæces were passed voluntarily, but the bronchial condition remained bad and pyrexia continued. On the third day a fæcal fistula developed and patient had fresh pain and tenderness and a return of distension in the upper abdomen, suggesting, with a marked deterioration in his general condition, the possibility of a second perforation. Patient took fluids well, remained quite conscious and uncomplaining until his death on the fourth day after the operation (23rd day of disease).

POST-MORTEM EXAMINATION.

Patient had not wasted greatly. There was a generalised purulent peritonitis, more marked in the lower half of the abdomen, with matting of intestines, and much paralytic distension of stomach and bowel.

There was extensive ulceration of the lower ileum, showing commencing healing in some places; and deep, recent ulceration of cæcum, with a perforation and a neighbouring fæcal fistula. The appendix stump was sound; there were some small ulcers in the ascending colon. The spleen had regained its normal size, but was soft and diffluent.

The lungs were collapsed at their bases and elsewhere congested, while the upper lobes showed some compensatory emphysema. There were tracheitis and bronchitis. The other organs were normal in appearance, except for cloudy swelling of the kidneys and a pale liver.

The post-mortem examination suggested that the inelastic epigastric swelling taken for intraperitoneal gas in the second instance may have been due to an atonic, dilated stomach.

CONCLUSIONS DRAWN FROM CASE.

1. That even with early diagnosis and nursing in a favourable posture for localisation of peritonitis, operation for perforation offers a very poor chance of recovery if general symptoms, and more particularly bronchitis and bronchiolitis, with cough, are still present.

2. That a return, after an abatement, of diarrhœa should always suggest a second crop of ulcers and call for even closer observation of the case. A previous case of perforation seen by the writer in a Belgian civilian during the 1915 epidemic, the only other case of perforation in his series, had a very definite second crop of ulcers.

3. That in enteric fever all the classical signs of perforation, with the exception of abdominal tenderness, may be absent.

One further point of interest in this case was that, in the search for the "carrier" in the patient's regiment, an eleven years' carrier, not of paratyphosus B., but of B. typhosus, was discovered.

(To be continued).

Guy's Hospital War Memorial.

DEAR SIR (or MADAM),

The Committee formed to collect funds for the establishment of a permanent Memorial in connection with the War have endeavoured to find out the character of the memorial which would appeal most to the subscribers. Certain objections have been raised to some of the suggested proposals set forth in the first appeal issued in November, 1918. It appears that there are but few widows and orphans left by Guy's men who have fallen in the war, and few men have been permanently disabled; but it will be considered as a first charge upon the Guy's Hospital War Memorial Fund to help the education of children of Guy's men who have fallen or died in the war, should such help be required. There is, moreover, the Royal Army Medical Corps Auxiliary Fund which helps in a generous manner the widows, and also assists in the education of orphans and of children of those who are permanently disabled.

As it therefore appears that little money will be required for the above primary obligation of the Fund, three additional proposals are now placed before those who have subscribed, or may wish to subscribe, to the War Memorial:—

1. A portion of the fund to be devoted to the new "Clinical" Ward shortly to be built, which should be called the "War Memorial Clinical Ward," and have inscribed upon its walls the names of the Guy's men who have lost their lives owing to the war. It is thought by some that "Clinical" Ward, associated as it is with old and great traditions, might specially appeal to old Guy's men, and also to parents and relations, as a most fitting place in which to inscribe the names and to commemorate the deeds of those who have died in the service of their country and hospital.

2. The adornment of the Dining Hall of the College, including memorial panels bearing the names of the Guy's men who have lost their lives in the war.

3. A portion of the Fund to be allocated to form the nucleus for endowment of a Dental Research Scholarship.

It has been decided to close the Fund on the 30th September, 1919, and to call a General Meeting of the subscribers in October, 1919, to decide upon the form or forms which the Memorial should take.

We enclose a copy of the original appeal, and hope that we shall enlist your interest and support, and that you will indicate which of the various proposals you prefer.

We are, Dear Sir (or Madam),

Yours faithfully,

H. COSMO O. BONSOR.
W. A. MAGGS.
LAURISTON E. SHAW.
ALFRED D. FRIPP.
Joint Treasurers.

June, 1919.

Original Appeal.

DEAR SIR (or MADAM),

There is a widespread desire amongst all connected with Guy's Hospital that a permanent Memorial should be established in connection with the War. It is felt that whatever form the Memorial may take it should worthily commemorate, not only the sacrifice of those Guy's men who have given their lives for their Country, but also the devotion of all those who have rendered professional service, whether at home or abroad, to the Empire in its hour of need. It will never be possible to make an accurate record of the contribution that Guy's men have made towards the great effort of the Empire and its Allies, but already we have to deplore the death on active service of more than 100 of our past and present Students, whilst the roll of those who have served their country by attachment to one or other of the Combatant Services numbers about 2,000.

A representative Committee, composed of Governors of the Hospital, Members of the Staffs of the Medical and Dental Schools, and Past and Present Students, has been formed to collect funds, and carry out the wishes of the Subscribers as to the character of the memorial. Amongst the proposals which have already been under the consideration of this Committee are the following:—

(*a*) A Memorial recording the names of Guy's Medical and Dental men who have fallen in the War to be placed within the precincts of the Hospital.

(*b*) A Fund to enable the sons of Guy's men, who have fallen, or suffered by the War, to receive free or assisted education at Guy's Hospital Medical or Dental Schools.

(*c*) A Fund to enable the daughters or widows of Guy's men, who have fallen, or suffered by the War, to receive free or assisted education as Nurses or Pupils in the Special Departments (such as the Massage and Light Departments) of the Hospital which are open to Women.

(*d*) An Endowment Fund for Entrance Scholarships to be open, in the first place, to the sons of old Guy's men.

The Committee will be grateful for any expression by Subscribers as to their preference for one or more of the proposals set out above, or for any other suggestions that may appear to individual Subscribers to be worthy of consideration. Later on it is intended to call a General Meeting of Subscribers, before whom will be laid the definite recommendations of the Committee as to the nature of the Memorial or Memorials in a more detailed form. The recommendations of the Committee will naturally depend upon the total sum which may appear likely to be available, and the indications that may be received as to the wishes of the Subscribers.

Subscriptions within the Hospital, varying from £250 to £1 1s. 0d., have been received already, and we express the hope that you will personally respond to this appeal in the most generous manner possible, and will do your best to make the project known amongst any who you may think are likely to be interested.

It has been arranged that Subscriptions may, if so desired, be spread over a period of five years, or may be paid in National War Bonds or Stock.

We, who sign this letter, have been asked to make known to all interested that a Subscription List has been opened, and that contributions should be sent to the Honorary Secretary of "Guy's Hospital War Memorial Fund," Guy's Hospital, London, S.E. 1. Cheques to be drawn in favour of "Guy's Hospital War Memorial Fund," and crossed "Bank of England."

A first List of Subscribers will be published in the GUY'S HOSPITAL GAZETTE next month, including all subscriptions received before December 9th.

We are, Dear Sir (or Madam),
Yours faithfully,

H. COSMO O. BONSOR, *President of the Hospital,*
W. A. MAGGS, *Consulting Dental Surgeon,*
LAURISTON E. SHAW, *Senior Physician,*
ALFRED D. FRIPP, *Senior Surgeon,*
Joint Treasurers.

November, 1918.

	£	s.	d.
Brought forward ...	4,269	16	10
Merry, A. W.	10	0	0
Reynolds, W. L. E.	5	5	0
Tyson, Wilson *	3	3	0
Stewart, Sir Charles J.	2	2	0
Bevan Brown, F. V.	2	2	0
Williams, O. E.	3	3	0
Robertson, F. M.	2	2	0
Wiles, J. H.	1	1	0
Makepeace, A. J.	2	2	0
Butler, J. A.	1	1	0
Joint, M. C.	3	3	0
George, W. S. †	1	1	0
East, A. G.	1	1	0
Dowsett, E. B....	10	10	0
Stephens, Lockhart E. W.	5	5	0
Kirkman, A. H. B.	1	1	0
Vincent, H. E....	1	1	0
Marshall, G.	2	2	0
Lewin, G.	2	2	0
Lower, N. Y.	1	1	0
Knaggs, R. Lawford	5	0	0
Jones, F. J. F.	0	10	6
Richmond, F.	1	1	0
Warner, R. G. Heegaard	5	5	0
Goodey, A.	2	2	0
Lakeman, W. S.	2	2	0
Carling, W.	5	5	0
Cave, F. E.	5	5	0
Trounce, T. R.	2	2	0
Biddulph, Hon. John, M.G.	10	0	0
Pye-Smith, C. D.	3	3	0
St. Cedd, R. G. Whitworth	1	1	0
Allport, A.	5	5	0
Lawson, G. L. L.	1	1	0
Nivison, Sir Robert, Bart.	100	0	0
Smith, H. Joste	1	1	0
Fothergill, C. F.	3	3	0
Warner, N. S. Heegaard	3	3	0
Iredell, C. E.	10	10	0
Campbell, J. M. B.	2	0	0
Chapple, H.	26	5	0
Mahon, E. M.	1	1	0
	£4,526	10	4

*1st instalment in respect of total contribution of £6 6s.
† " " " " £5 5s.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *in any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

SIR,—The Government has invoked the help of the British people in relieving the distress from famine in Europe and Asia Minor. Lord Robert Cecil has expressed the hope that the relief agencies appealing to the public under the Government's offer to double all voluntary gifts (up to £200,000) raised in the United Kingdom, "will receive response that will bring to some millions of children . . . a message of practical sympathy." "There is no doubt whatever," said Lord Robert in the Commons on the 21st ulto., "that in large parts of Central Europe, including some parts of Germany, the children, the babies, are actually dying from want of food and want of milk. I do not believe that can be questioned."

Other distinguished men appeal to us. Lord Curzon sends out "an urgent call to the people of the British Empire to play their part in the great task of reconciliation and mercy." General Smuts asks us all "to exert ourselves to the utmost in the great work of saving the wreckage of life and industry." Sir William Goode, British Director of Relief Missions in Paris, writes to tell us that twelve and a half millions are being spent by our Government in Europe, and this sum will all be used up or allocated before the harvest. Still there will be urgent need, he says, for medical comforts and for supplementary food, particularly for the children.

Will you be so good as to allow us space to remind your readers that the Save the Children Fund (Hon. Sec.: Mrs. Buxton, 328, High Holborn, W.C.1.) has set itself the task of carrying this message to the nation? This is a Central Relief Fund to be administered through the various excellent relief agencies which are at work in different parts of the famine areas. The Fund does not confine itself within the limitations of the Government grant (Germany and part of Russia are excluded from benefit), but sends help where help is most needed irrespective of nationality. Donations, however, may be earmarked for any particular country. "What you have already done," writes Mr. C. K. Butler, Head of the British Mission to Vienna, "has been and will be of incalculable benefit to the suffering."

This great work is the first life saving scheme of International scope, and it may prove to be the greatest mission that compassionate men have ever embarked upon. It can only succeed if people of all classes, parties and beliefs will unite and ally their efforts with those of the Government.—Yours, etc.,

7th August, 1919.

HENRY BENTINCK.
BUCKMASTER.
MARY R. MACARTHUR.
PAMELA McKENNA.

Dear Mr. Editor,—I have received from the widow of an old Guy's man a letter stating that she has a collection of her husband's medical and surgical instruments of which she is desirous of disposing. I enclose herewith a list of the instruments in question which have been priced by a medical man.

As there must be many men among your readers who might wish to purchase articles named in the list, and as the prices of instruments are notoriously high at present, I thought perhaps you might see your way to publishing the list, with this note by way of explanation.

I feel sure that the Gazette would not take exception to acting as intermediary in the sale of the articles.—

Yours faithfully. "REGISTRAR."

Guy's Hospital,
London, S.E.1.
August 7th, 1919.

Trocar	3/6	Test Tube Stand ...	2/-
Enasim	8/6	Hypodermic Syringe	3/6
Chlorethyl Inhaler	2/6	7 pairs Tooth Forceps	21/-
Uterine Probe ...	2/-	Aneurysm needle ...	1/-
Nasal Speculum ...	2/-	Volsellem Forceps...	5/-
Rectal Speculum ...	4/-	Nasal Polypus Snare	10/-
Aural Speculum ...	4/-	Aural Speculum ...	4/-
Ovum Forceps ...	4/6	Small Midwifery Forceps	8/-
Dimlafoy's Aspirator	24/-	Perforator	10/-
Rectal Speculum ...	4/-	Craneotomy Forceps	10/-
Wooden Stethoscope	1/-	Blunt Hook ...	3/-
Spirit Lamp ...	1/-	Ear Syringe ...	10/-
Catheters (metal) ...	15/-	Mid. Forceps ...	10/-
Scalpels ...	8/6	Binaural Stethoscope	2/-
Amputation Knives	12/-	Beck's London Microscope	£14 14/-
Furgusan's Speculum	3/-		
Stomach Pump ...	18/-		

Application for these instruments should be made to the Editor, Guy's Hospital Gazette, Guy's Hospital, S.E.1.

List of Interesting Cases in the Wards.

MEDICAL.

Addison 1.—Subacute nephritis.
" 10.—Effects of gas poisoning.
" 21.—Hypothyroidism.
" 47.—Pericarditis.
Mary 27.—Acute rheumatism. Pericarditis. Endocarditis.
" 16.—Auricular fibrillation.
" 10. Chorea. Pericarditis.
Stephen 43.—Purpura hæmorrhagia.
Esther 12.—? Addison's disease.
Miriam 8.—Congenital laryngeal stridor.

SURGICAL.

Lazarus 3.—? Tubercular abscesses in calves.
Lydia (Cot D).—Meningocele.
Charity 8. - Hydronephrosis.
Dorcas 22.—Involvement of ulnar nerve in callus.
Luke 9. -Chronic intestinal obstruction.
" 11.—? Carcinoma of thyroid.
Evelyn 2.—Fractured patella.
" 16.—Fracture of lower end of femur involving knee-joint.
Cornelius (Cot B). - Lacerated leg. Ingenious splinting.

The British Dental Association.

The Annual Meeting.

DENTISTRY AND THE STATE.

In his Presidential Address at the Annual Meeting of the British Dental Association in London, on Friday, August 8th, Mr. Montagu F. Hopson, L.D.S. Eng. (President) said the outbreak of the great war found H.M. Forces quite unprepared dentally, and there was no organized dental unit, either for home or field purposes. Their Executive at once placed all the resources of the Association at the disposal of the Government, but expert advice was rejected.

Proceeding, Mr. Hopson said: "That Service dental arrangements were mis-handled, not to say bungled, is generally admitted. Failure to grasp the situation may have been due to ignorance on the part of the chiefs of the Army Medical Department to begin with, but they later displayed a culpable obstinacy in the matter which led to a grave wastage of man-power and a large amount of unnecessary and easily preventable disease and suffering amongst the troops in the field and the wounded in our hospitals. The policy of our Executive was clear and definite, and was finally vindicated, viz., that with an acknowledged general shortage of dentists even to meet the needs of the civil population, they could most advantageously serve their country in the national emergency, in their professional capacity, and that all should be mobilised for service. The slow stages by which the recognition of so obvious a fact was reached you are familiar with. Dentists commissioned as Temporary Lieutenants on the general list were appointed in driblets and were employed under the supervision of medical officers possessing no dental knowledge. There was an utter lack of organisation. Examples of efficiency furnished by our Colonial Forces were persistently ignored. In the meanwhile skilled and highly-trained men were being wasted in the ranks, the proffered services of those possessing expert knowledge in the treatment of facial injuries were declined, and our dental schools, the nurseries of professional recruits, were depleted.

"For three whole years the Government remained indifferent to the value and importance of the dental surgeon as a national asset. As the War drew to its victorious close some sort of order gradually evolved in army dental arrangements, but there was still lacking that one essential to an efficient organisation—an administrator, possessing a dental qualification, and given unhampered authority over the men under his command. It is manifest that whilst army dental treatment must be closely linked with the Royal Army Medical Corps, it can never be adequate until a definite Dental Corps has been established, modelled on the lines adopted by our Colonies and certain of our Allies. Similar corps must be formed for the

Navy and Air Force. Hence it is with profound regret and no small amount of misgiving, that I read the new regulations promulgated as to Dental Service in the Navy. They are unworthy of a great service and offer an indignity to our profession."

They might well be proud of the services rendered to the nation during the war; no profession of its size did more gratuitous work and all that it accomplished was done in spite of official opposition placed in its way. Some 1,300 dentists joined the Forces, and sixty were killed in action or died on service. A large number also rendered exceptionally valuable service as civilian dental surgeons in the treatment of wounds of the face and jaws in the war hospitals at home, and practically every man served his country in some way or another in a voluntary professional capacity.

Referring to the important report recently issued by the Dentists Act Committee, Mr. Hopson emphasised its statement that "the State cannot afford to allow the health of the workers of the nation to be continuously undermined by dental neglect. Steps should be taken without delay to recognise dentistry as one of the chief, if not the chief, means of preventing ill-health." The position assigned to the dental profession was one of the chief outposts of preventive medicine.

What more honourable post could they desire? If they were to hold it with success a large and highly-trained body of men will be required. Further, that outpost must be assured of all the help and succour it may need. *In other words, if dentistry is to help the State, the State must help dentistry* in education and in research. The new Education Act provided for the dental treatment of all children of school age. The Dentists Act Committee went a step further and rightly insisted that dental treatment should be rendered available for all needing it. A Committee of the Association had drawn up a scheme for a complete public dental service. There could be no doubt that thousands of persons were receiving sickness benefit who would not be doing so had they received proper dental treatment. The Government had the recommendations of their Departmental Committee as a basis for legislation and upon this they must act.

The Annual Report, which was adopted, stated that the membership of the Association had increased to 3,000, and that during the war seven members gained the D.S.O. (two with bar) and 23 the Military Cross (two with bar), while three had been awarded the C.B.E. and 25 the O.B.E. and M.B.E.

Papers by Guy's Men.

Capt. K. Oslack: (*a*) A case of perforation of a gastric ulcer due to an accident. (*b*) A case of calculous pyonephrosis complicated by urethral stricture. Internal urethrotomy, nephrectomy and recovery.—*Indian Medical Gazette*, Feb., 1918.

Extracts from the Letters of a London Medical Student.

(*Continued.*)

London, July 8th, 1816.

. . . Brookes has now got on as far as the Abdominal Viscera. It is nearly a fortnight since he began on Myology, and we have had the same subject for every lecture, and that was in the house three or four days before the lectures on Myology commenced. We had a woman brought in three weeks ago which was drowned in the Regent's Canal. She is the fattest carcase I ever saw, so much so, that none of the pupils would take her.* Her thigh is larger in circumference than my body. Three or four operations have been performed on her, and the fat is four inches deep in some places. Indeed, she is a ball of grease, and is now lying in the dissecting room untouched, except that one hip, shoulder, and heart, and her skull cap are taken off. She stinks most abominably, and when the sun shines hot, the yellow globules of melted fat run from her upon the floor, like fresh butter, and in the evening it congeals there like little saffron buns. I took a gentleman into the dissecting room last Monday, but he could not stand it a second, nor could I persuade him to enter it again.

*July 9th.—I find to-day that a Scotchman has taken half of her for half a guinea.

London, Augt. 6th, 1816.

. . . I now go to Brookes' twice every day, and fill up the intervals with reading, writing, and visiting. I study the human character pretty much, for I find I am a most complete novice in the world. I think I am getting on, and trust by my return I shall be an adept at dissimulation. I am perfectly convinced of the truth of your observation that it is necessary to adopt system in my studies. You attended Brookes and the Borough Hospitals at the same time under greater disadvantages than myself, since I have had an opportunity of acquiring some knowledge of Anatomy, previous to my commencing my studies on Surgery, etc. How did you contrive to attend both at once? Is there time in the eight

hours days of winter to attend the lectures and practice of those Hosptials, and the lecture and dissection at Brookes' (allowing a proper time to walk from one to another), without the inconvenience of missing perhaps some lectures at times, arriving late at others, and hurrying through the wards of the hospitals, and the dissecting room? I wish particularly to be informed on this point, as I am a perpetual pupil with Brookes, and should prefer attending the Hospitals in the Borough if possible. I have been told that I cannot attend both. As you did, I shall be glad if you will inform me how you divided your time so as to attend both with advantage. Be particularly explicit on this head. You are well acquainted with my present situation, and I shall feel very much obliged to you if you will state the plan you think most advisable for me to adopt. You will leave the fatigue of walking to Brookes out of the question, since, if I have time for the different lectures, the walking six miles will be rather beneficial than otherwise, after the severe exercise I have been obliged to take all the summer. You altogether mistake my meaning, in giving my description of the dissecting rooms the preference to Lord Byron's Alp. I meant to say that my description was more calculated to shock the feelings of those who are so fashionable as to have weak nerves, from its being equally horrible with Lord Byron's, and a reality as well.

(*To be continued.*)

Guy's '89 Club.

The Victory Meeting and Dinner will take place at Jules' Restaurant, Jermyn Street, S.W., on Wednesday, October 8th next, at 6.30 p.m. The President, W. Sampson Handley, will be in the chair, and it is hoped that there will be a record attendance of members. Reply post-cards will be posted shortly by the Hon. Secretary, H. J. Spon, 61, Harley Street, W.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Sir James F. Goodhart,

M.D., F.R.C.P., LL.D. (Aberd.)

A Biographical Note.

Born in London on October 24th, 1845. Son of Alfred Harrington Goodhart, physician, of Camden Rd., N.W., who married Elizabeth Wilkinson, daughter of Alexander Goudge, of Sutton Place, N.E. Educated at Epsom College, where he was one of the original Foundationers.

Entered Guy's Hospital Medical School in 1864. Won the Gold Medal for Clinical Medicine, 1867. The following year he took the diplomas of M.R.C.S. and L.R.C.P. 1871, graduated M.B., C.M., with highest honours at the University of Aberdeen. In 1873 he took the degree of M.D. in the same University, which 26 years later bestowed on him the Honorary Degree of LL.D.

1871. He was appointed House Surgeon to the Evelina Hospital for Children, when it was first opened.

1872. Appointed Surgical Registrar to Guy's Hospital, became Demonstrator in Morbid Anatomy and Pathology, and in 1874 Medical Registrar.

1875. Physician to the Out-Patients, Evelina Hospital.

1877. Elected Assistant Physician to Guy's.

1881—1888. Full physician to the Evelina Hospital. 1889, Consulting Physician.

1882. Curator of Museum.

1884. Lecturer on Pathology to Medical School.

1886. Appointed Physician, Guy's Hospital; worked for 15 years in the Post-mortem Room.

1898. Resigned from Guy's and was appointed Consulting Physician in 1899.

1891. Delivered the Harveian Lectures before the Harveian Society of London. Secretary of the Section of Pathology and Bacteriology, B.M.A. Meeting, 1883, Vice-President 1886 and 1895. 1891, President of the Section of Children's Diseases, B.M.A. 1901, Delivered the Address in Medicine at Cheltenham, B.M.A.

1875. Member of the Royal College of Physicians. 1880, Elected Fellow. Examiner, 1889-92. Councillor, 1901—3. Censor, 1907.

1885. Bradshaw Lecturer. 1912. Harveian Orator.

1911. Received Baronetcy at the Coronation of King George.

1879. Married the daughter of Mr. William Bennett, J.P., of Ashgrove, Hereford. Lady Goodhart died in February, 1915.

Died Sunday, May 28th, 1916, at the age of 71 years.

Succeeded by elder son, a barrister; his second son, Gordon Goodhart, is Douglas Demonstrator of Pathology, Guy's Hospital.

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Compiled by J. H. E. WINSTON, Wills Librarian.

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Lawn Tennis.

The final round of the Lane-Washbourn Cup was played at Honor Oak Park on August 1st. between J. W. Schollum and A. C. Strawbawn. It was a very even game, but Strawbawn's steadiness told in the end. After winning the first set and being 4–3 in the second set, Schollum appeared to have every chance of the match. Strawbawn, however, managed to win the next three games. He made a point of keeping off Schollum's formidable forehand, and found in his backhand ground strokes a weak point.

Sir Arbuthnot Lane is very kindly presenting a replica of the Cup to the winner, as was his custom when President of the Guy's Hospital Lawn Tennis Club in pre-war days.

The Lane-Washbourn Cup was not won in 1914. War put an end to the competition. The pedestal of the Cup is nowhere to be found, so that the record of previous winners is unfortunately lost too. Any information as to what happened to it would be welcomed.

LANE-WASHBOURN CUP. OPEN SINGLES. G.H.L.T.C., JUNE-JULY, 1919.

BYES	1	T. Wooldridge	Wooldridge				
	2	H. Richards	w.o.	Muir-Smith			
	3	L. Lyne	Muir-Smith				
	4	C. H. Muir-Smith	7-5, 6-3		Sedgewick		
	5	P. A. Sedgewick	Sedgewick		w.o.		
	6	K. M. Woodruff	w.o.	Sedgewick			
	7	G. M. Stuart	Stuart	8-6, 1-6, 6-3			
	8	S. C. Bekkle	6-0, 6-0				
9	L. F. Whelpton		Greenway				
10	C. W. Greenway		w.o.	Greenway			
11	D. H. Berry		Tie	w.o.		Schollum	
12	F. W. Crook		Scratched		Gross		
13	J. J. Lewinstein		Gross		6-0, 6-3		
14	R. D. Gross		w.o.	Gross			
15	H. Evans		Felce	0-6, 8-6, 7-5			
16	G. W. Felce		6-3, 7-9, 6-3			Schollum	
17	D. B. Whitlock		Short			6-0, 6-2	
18	C. M. Short		6-2, 7-5	Mackay			
19	J. D. S. Thomas		Mackay	w.o.			
20	A. L. Mackay		6-2, 6-2		Schollum		
21	J. A. Currie		Krige		6-4, 6-0		
22	P. Krige		6-0, 6-1	Schollum			
23	J. W. Schollum		Schollum	12-10, 6-1			
24	F. J. Downing		6-3, 6-1				A. C. Strawbawn
25	H. S. Groves		Groves				5-7, 6-4, 6-3
26	G. Pomeroy		6-2, 8-6	Shaw			
27	G. D. Shaw		Shaw				
28	G. P. Lindsay		6-0, 6-0		Schlimmer		
29	B. L. Laver		Laver		7-5, 5-7, 6-3		
30	A. McKenzie		6-1, 6-0	Schlimmer			
31	R. Schlimmer		Schlimmer	1-6, 9-7, 6-4			
32	R. Hughes		6-0, 6-3			Schlimmer	
33	N. L. Lloyd		Lloyd			6-1, 6-0	
34	C. H. Edney		7-5, 6-1	Lloyd			
35	W. G. R. Hore		Coysh	6-0, 4-6, 9-7			
36	H. A. Coysh		6-1, 6-1		Bradfield		
37	G. R. O. Bradfield		Bradfield		6-1, 6-4		
38	G. C. W. Curzon		w.o.	Bradfield			Strawbawn
39	R. C. May		Meacock	4-6, 6-3, 6-4			2-6, 6-4, 6-3
40	G. P. Meacock		w.o.				
BYES	41	A. C. Strawbawn	Strawbawn				
	42	S. Rose	w.o.	Strawbawn			
	43	T. A. Shaw	Ratnagar	2-6, 6-4, 6-3			
	44	F. Ratnagar	6-4, 6-4			Strawbawn	
	45	M. Mackenzie	Daneel			6-2, 6-1	
	46	A. B. Daneel	6-2, 6-3	Daneel			
	47	J. Jemson	Garland				
	48	A. S. Garland	6-0, 6-1				

JUNIOR INTER-HOSPITAL CUP.—Semi-Final.

Guy's 2nd VI. v. Middlesex 2nd III.

Played on July 10th at Honor Oak Park. Guy's had no difficulty in winning by 11 matches to 1, 3 matches remaining unplayed. Scores :—

Singles.—J. Totton, Capt. (Guy's) beat Chena, 6–2, 6–8, 6–0; R. Schlimmer (Guy's) beat Yonge, 6–2, 5–7, 6–3; F. R. Ratnagar (Guy's) beat Bailey, 6–1, 6–1; P. G. Sedgewick (Guy's) beat Sibley, 6–3, 4–6, 6–1; R. Gross (Guy's) lost to Summers, 3–6, 6–4, 2–6; T. A. Shaw (Guy's) beat Bedford, 6–2, 3–6, 6–2.

Doubles.—Totton and Sedgewick (Guy's) beat Chena and Yonge, 6–2. 6–1; beat Bailey and Sibley, 6–1, 6–4; beat Summers and Bedford, 7–5, 6–0. Schlimmer and Gross (Guy's) beat Bailey and Sibley, 9-11, 6–4, 8–6. T. A. Shaw and Ratnagar (Guy's) beat Chena and Yonge, 6–4, 6–4; beat Summers and Bedford, 6–4, 6–3.

The Final Round.

Guy's 2nd VI. v. Bart.'s 2nd VI.

Played at Winchmore Hill on July 18th. Guy's won by 9 matches to 3, 3 matches being left unplayed.

Singles.—J. Totton, Capt. (Guy's) lost to Douglas (Bart.'s), 2–6, 6–4, 5–7: R. Slimmer lost to Cody, 2–6, 2–6; A. L. McKay beat Morgan, 6–2, 7–5; F. R. Ratnagar beat Joule, 5–7, 6–3, 6–0; P. G. Sedgewick beat Visick, 8–6, 6–3; T. A. Shaw beat Hayes, 6–4, 8–6.

Doubles.—Totton and Sedgwick (Guy's) beat Douglas and Cody, 4–6, 6–2, 6–2; beat Morgan and Visick, 6–0, 6–2; beat Joule and Hayes, 6–0, 6–1. Schlimmer and McKay (Guy's) beat Douglas and Cody, 6–4, 6–2; beat Morgan and Visick, 6–0, 6–0; Ratnagar and Shaw (Guy's) lost to Joule and Hayes, 6–0, 7–9, 4–6.

The winners in 1914 were King's College Hospital, who did not compete this year. After our severe defeat in the Senior Cup, our success in the Junior Competition is very welcome.

GUY'S v. WALLINGTON.

This match was played at Honor Oak Park on August 2nd. It resulted in a win for Wallington after a very close finish.

A. C. Strawbawn and J. W. Schollum (Guy's) lost to Smith and Dumayne, 6–8, 4–6; lost to Speed and Wilson, 2–6, 4–6; beat Winter and Lane, 7–5, 6–0.

A. B. Daniel and R. Schlimmer (Guy's) lost to Smith and Dumayne, 5–7, 6–2, 2–6; beat Speed and Wilson, 6–3, 6–2; beat Winter and Lane, 6–3, 6–2.

—. Woodruff and A. McKay (Guy's) lost to Smith and Dumayne, 3–6, 0–6; lost to Speed and Wilson, 6–1, 8–10, 5–7; beat Winter and Lane, 6–2, 6–4.

Results.—Wallington 5 matches, Guy's 4 matches.

Daniel and Schlimmer gave the best account of themselves and went within an ace of beating their first pair. Strawbawn and Schollum both had an off day. The score near the end stood at 4 matches all; McKay and Woodruff (Guy's) and Speed and Wilson (Wallington) were a set all for the deciding set. The latter were leading 5–3. Then the score became 5–5, but Wallington ran out 7–5. This last match was unfortunately interfered with by rain and very bad light.

NEST-ANGLO SPORTS CLUB v. GUY'S 2nd VI.

This match was played at Elmer's End on Aug. 2nd, and Guy's were just defeated—5 matches to 4. Unfortunately our team was one short, and our opponents kindly provided a sub. Scores :—

T. Wooldridge and T. A. Shaw (Guy's) beat Harrison and Singh, 6–2, 6–1; beat Bowes and Tapsell, 6–2, 6–4; beat Baker and Bischoff, 6–3, 4–6, 6–1.

—. Walters and R. D. Grosse (Guy's) lost to Harrison and Singh, 5–7, 2–6; lost to Bowes and Tapsell, 2–6, 4–6; beat Baker and Bischoff, 9–7, 6–8, 7–5.

G. P. Lindsay and Sub. (Guy's) lost to Harrison and Singh, 4–6, 2–6; lost to Bowes and Tapsell, 1–6, 7–5, 4–6; lost to Baker and Bischoff, 6–8, 3–6.

Change of Address.

Capt. J. Stephenson, R.A.M.C., 58 C.C.S., British Troops in France.

Capt. R. W. Cushing, R.A.M.C.(T.F.), Military Hospital, Bury.

John Z. Hanafy, 16, Croft Terrace, Jarrow-on-Tyne.

Capt. M. B. M. Tweed, N.Z.M.C., Guy's Hospital, S.E. 1.

Dr. R. Denman, 5, Burlington Avenue, Kew, Surrey.

C. H. Ripman, M.D., 12, Park Square, W., Regent's Park, N.W. 1. (Tel. Mayfair 1480.)

Dr. & Mrs. N. Mutch, 16, Harcourt House, Cavendish Square. (Tel. Mayfair 5033).

Dr. H. Corry Mann, 25, Harrington Gardens, South Kensington, S.W. 7. (Tel. Kensingt. 3236); and Guy's Hospital, S.E. 1.

Capt. H. B. Wilkinson, R.A.M.C., Blackadon, Ivybridge, S. Devon.

Births.

INGRAM.—On August 5th, the wife of P. C. P. Ingram, M.B., B.S. Lond., of Stow Park Avenue, Newport, Mon.—a son.

STONER.—On August 6th, at a Nursing Home in Hove, the wife of Patrick Stoner, L.D.S.Eng.—a son.

Marriages.

DEBENHAM—ARCHER-SHEE.—The marriage arranged between Leonard S. Debenham, M.B., B.S., B.Sc., and Anna, youngest daughter of the late Martin Archer-Shee, will take place on Sept. 2nd, at the Chapel of SS. Peter & Edward, Palace Street, Westminster, S.W., at 11 a.m. All friends will be welcome at the Church, and after the ceremony at the St. James's Palace Hotel, Bury Street, S.W.

Ed.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

MAY we once more remind our readers that the sum subscribed towards the Guy's War Memorial has not come up to expectations. We publish elsewhere yet another letter regarding the way in which the fund is to be utilised, but whatever tangible form the Memorial is eventually to take, all will agree that our first and immediate duty is to raise such a sum as shall be worthy of the memory of the great and glorious dead. Such a sum as shall enable us to hand down to posterity something of real abiding beauty and utility, for while we know that the memory of those gallant souls who laid down their lives that those of us who remain may live in peace will never grow dim, we would have something amongst us which shall perpetuate, not only to us, but to those who are to work within these walls in years to come, the memory of the many Guy's men who have laid down their lives. The subscription list for the Memorial Fund is to be closed at the end of the present month.

WE reproduce on another page a notice received from the Royal College of Surgeons regarding the special examination for the Primary Fellowship in the hope that it may be of interest to qualified men who have returned from the Army and Naval Medical Services. It will be noted that approved candidates are exempted from much of the more tedious academic portion of the examination.

AT the urgent request of the Acting Chaplain we would call the attention of men to the Chapel choir. That a students' choir should come every Sunday evening at 7 is an old Hospital custom, and many of the top-hatted grave seniors who now pace the colonnade with measured step once led the singing in the choir. Will all those who will help, roll up to the Chaplain's room at 6.45 on Sunday evenings and thus help to keep going one of the old traditions. All the insignia of office are found.

The majority of men, of course, get away from the Hospital on Sundays or week ends when possible, and it cannot be expected that any individual man will turn up regularly, but if the help of a number of men could be enlisted and the presence of a few each week thus ensured, it would do much to gladden the heart of the chaplain and organist and to add to the interest of the chapel services.

WE should like to take this opportunity of welcoming back among us—unfortunately for a few weeks only—the Rev. A. E. Popham, who

is at present doing duty as chaplain. Mr. Popham was here for some years before the war, and has recently done gallant service in France. During the short time that he has now been with us again he has endeared himself to all—patients and staff alike, and his departure will be met with universal regret.

WE do not know much of the decisions arrived at as a result of the recent strenuous activities of the Reconstruction Committee, but, without presuming to criticise a scheme of which we are ignorant of the details, we should like to mention several defects in our present scheme of medical education which we hope to see remedied. Criticism of the destructive variety is always easy, and while we can readily put our finger on items in the curriculum which appear superfluous, it is not so easy to opine in exactly what direction the instruction should be extended. In this connection it should be borne in mind that the best of our brains are only retentive to a certain degree, and therefore whatever knowledge we are to acquire must inevitably be instilled into us accompanied by a certain amount of padding. Thus, the man who reads a classical text-book derives far more benefit from his labours than he who relies on a "cram" book as his fount of knowledge, simply because the tabloid information of the "cram" book, being entirely devoid of the unessential, altogether exceeds his power of assimilation.

In the first year studies there is room for paring in the subject of Biology. Botany we believe to be quite the most futile and redundant subject in the whole of the medical student's curriculum. Personally, we confess that when preparing for our first examination we committed to memory long botanical rigmaroles of the meaning of which we had not the faintest inkling, and that botany is the one and only subject of which we have never for one moment had cause to regret that our knowledge of it was not more profound. With regard to Chemistry and Physics, on the other hand, we do not consider that there is any appreciable superfluity. A comprehensive knowledge of these subjects is essential not only to the subsequent intelligent study of physiology, but also to the study of medicine and surgery. With regard to anatomy and physiology, we should be loth to see the syllabus cut down in any respect. It is maintained by some that in Anatomy we are taught a great deal that is unessential. Much anatomy is of no surgical importance at present. For instance, we know of no surgical operation for the performance of which an intimate knowledge of the course of the lesser superficial petrosal nerve is a necessity, yet we prefer to remember with pride that time was when not only the petrosals, but many other apparently unimportant and insignificant structures were an open book to us.

With regard to Medicine, Surgery, and allied subjects we can deal but briefly. We believe that in many respects the teaching in this Hospital is second to none, and in those subjects in which it is not all it might be, it is probably not inferior to the teaching at other hospitals. It is, perhaps, in the special subjects that there is most room for dissatisfaction. The teaching in most of these subjects is excellent, but is it not desirable that every man should have a grounding in *all* the special subjects? After all, there is no getting away from the fact that the *majority* of men are going to be neither operating surgeons nor consulting physicians, but common or garden doctors. Surely it is desirable that every man should know something of all the commoner pathological conditions with which he is liable to come into contact. Many men at present qualify who have never set foot

in the Children's Department, are absolutely ignorant of the rudiments of ophthalmology, have not the vaguest idea how to treat eczema, have never seen a naso-pharynx nor used an aural speculum, or are quite incapable of distinguishing a ringworm from alopecia areata. And yet these very men when they qualify are probably full to overflowing with knowledge of tabes, tumours, and trematodes.

With the excellent facilities and teachers at our disposal it seems a pity that more comprehensive instruction is not given in Bacteriology. All men do a course in bacteriology when ward-clerks. They begin by going through an elaborate performance with a piece of meat wherewith they make culture media by methods which they have entirely forgotten a week afterwards. They stain and examine all the common organisms, but of their culture reactions and other characteristics they are taught little and remember less. It is no exaggeration to say that not one man in ten when he qualifies could distinguish bacillus coli in a culture tube from streptococcus longus.

Again, in matters appertaining to the Light Department the average man is absolutely ignorant. He has a vague notion that X-rays, radium, and diathermy are used for the treatment of malignant growths, but of the indications for and the results of each he knows nothing. Finsen light and ionisation are to him little more than names, and why ringworm on the scalp is promptly packed off to be X-rayed whereas ringworm elsewhere is not, remains a perpetual mystery to him.

Far be it from us to discourage any of the younger men by drawing harrowing pictures of the multifarious activities in which they will be called upon to engage, but let us rather impress upon them that with few exceptions the whole of their medical curriculum hangs together, that chemistry and physics, anatomy and physiology, are the groundstones of the sciences of medicine and surgery, and that the more solid are the foundations of the first years, so will diminish the difficulties of adding the superstructure.

We would draw attention to the meetings of the Hospital Choral Society to be held on Fridays, beginning this week. We have been fortunate in securing the services of a particularly capable and enthusiastic choir-master in the person of Mr. H. St. J. Bradford. The place of meeting will be the Physiological Theatre and the time 8 p.m. Will all those with voices—however humble—and any taste for music endeavour to turn up?

Overheard in the Surgery.

"Yes, Nurse, my chap's in India. On the north-west frontier he is, fighting the Africans!"

Cheerful Old Soul with Colles' Fracture:—"Yes, I'm eighty-seven, I am, doctor. I've been married twice, and I'll get married again before I die! How much do ye think Lloyd George'd give me if I had twins?"

Honours.

M.C.

Capt. (Act. Maj.) A. L. Shearwood, attch. 33rd Field Ambulance.—For conspicuous gallantry and devotion to duty on September 27–28, 1918, during and after the attack on Oisy-le-Verger and Epinoy, when in charge of the evacuation of the wounded from the divisional front by motor ambulance. He worked for 36 hours unceasingly, visiting forward positions and establishing car-posts under shell fire. His initiative and skill in carrying out these dispositions and his complete disregard for personal danger and fine example to all those under his command, saved many lives and rendered the evacuation a complete success.

A Further Lecture on Gall-Stones.

CLINICAL LECTURE BY MR. E. C. HUGHES.

GENTLEMEN,—May I remind you of a few points in my last lecture to you on gall-stones? First, how very common the occurrence of gall-stones is, and particularly in females, nearly all of whom have borne children. The stones are composed of cholesterin and calcium bilirubin in varying proportions, and this deposit in the biliary passages is the result of an inflammation of the mucous membrane resulting in a desquamation of the lining epithelium and an increased production of mucus, the inflammation being due to micro-organisms which have, in most cases, reached the gall-bladder from the duodenum, and at the same time have obstructed the outflow of bile by causing a swelling of the mucous membrane of the biliary passages.

So unexpectedly do gall-stones turn up in the post-mortem room without apparently having caused symptoms that it has been said that they may be present without causing symptoms. Is this so? In patients coming to operation, nearly all have had long-continued indigestion preceding the acute symptoms that have led the patient to seek operation; and, further, at other operations, where the symptoms are of short duration, the pathological findings are obviously old.

The symptoms due to gall-stones are due to two factors: (1) The pain due to the tension and particularly the involvement of the peritoneum in the inflammation caused by the stones; (2) The pain caused by the contraction of the involuntary muscle of the biliary passages trying to pass a stone against resistance along the bile ducts to the duodenum.

The symptoms arising from involvement of the peritoneum will cause symptoms exactly comparable to an attack of appendicitis, where the pain is due almost entirely to the peritoneal involvement.

In a typical case of acute cholecystitis or inflammation of the gall-bladder, there will be a rise of temperature, vomiting, constipation, tenderness, pain, and muscular rigidity, exactly the same symptoms as in appendicitis. As a rule, no mistake will be made, as the symptoms are referred to the neighbourhood of the ninth costal cartilage, and, in addition, there may be the characteristic right scapular pain.

The symptoms arising from a stone passing down the biliary passages give rise to biliary colic, which in its severe form causes most abominable pain, in the upper abdomen, and shooting through to the right shoulder, a rigor, nausea, vomiting, and shock.

These are the two essential symptoms of gall-stones, pain due to the tension of and involvement of the peritoneum, and pain due to the huge effort of the involuntary muscles of the biliary passages.

Only one other symptom that is at all constant is the rise of temperature. In an acute cholecystitis, the fever depends on the severity of the inflammation, while in "colic" cases, each attack is accompanied by a rigor or a sudden rise of temperature. Moynihan draws attention to the typical chart of gall-stone patients, showing how every now and again there is a sudden rise and fall of temperature. So characteristic is it that he calls it the "steeple chart." He has also drawn attention to the fact that people coming with obvious gall-stone symptoms have suffered every now and then in the past from "goose-flesh," or slight sudden attacks of chilliness, which no doubt

were mild rigors due to gall-stone inflammation.

The other symptoms that may accompany the above three symptoms, the pain of the peritoneal involvement, the pain of the colic, and the temperature, are jaundice, a tumour, or enlargement of the liver.

As regards jaundice, you will bear in mind that the majority of gall-stone patients do not get jaundice, which, as a rule, only occurs with stones in the common duct.

It does occasionally accompany stones in the gall-bladder and cystic duct, and the explanation of this is that the swelling of the mucous membrane of the gall-bladder due to the inflammation is not confined to that part only, but spreads into the common duct; and the swelling of the mucous membrane of the duct is sufficient to cause a temporary obstruction to the outflow of bile.

The jaundice due to stones in the common duct is, as a rule, intermittent: there are recurrent attacks of colic, each attack being followed by jaundice which gradually clears away. In these cases the gall-stone is impacted in a narrow part of the common duct, which is or has been inflamed. As a result of these attacks of inflammation and the damming up of the bile behind the obstruction, the proximal part of the common duct becomes distended. During the colic, when the involuntary muscle of the biliary passages are contracting in an attempt to force the stone or stones into the duodenum (it is far more common at operation to find multiple stones rather than a solitary stone), the stone is forced into a narrowed part; when the colic passes off, the stone drops back into a dilated part of the duct so that the bile can again pass into the duodenum. This pathological result has been well described as a ball-valve arrangement.

A jaundice that develops without pain and steadily becomes deeper without any ebbing and flowing is very likely to be an obstruction of the common duct due to growth and very unlikely to be due to stones.

Other signs that do or may accompany jaundice, the pale stools, the dark urine, the itching of the skin, the slow pulse, I will only mention, but I want to remind you of the increased coagulation time of the blood. All jaundiced patients before operation should have their coagulation time tested, and if it is found unduly long, no operation should be performed until it is approximately normal, for it is said that these patients are very liable to bleed.

The routine treatment is to give calcium by the mouth and in three or four days the coagulation time should be normal. Recently Dr. Ryffel in one of my cases, finding that no change occurred by giving it by mouth, injected the calcium intramuscularly and within a few hours the coagulation period was normal.

I want to remind you of one other point, and that is, a patient, who has been jaundiced for some time, may waste, and may do this to such an extent as to make one suspicious of malignant disease. There only remains the other two occasional symptoms, the tumour and the enlargement of the liver. About the latter there is very commonly a slight general enlargement of the liver following an impaction of the stone in the common duct; and there is that peculiar tongue-like lobe of liver tissue, Riedel's lobe, which, I believe, is only found in patients suffering from gall-stones. About the tumour formation, it can be stated that a tumour only occurs in connection with stones in the gall-bladder and cystic duct, and, further, that it is far more common to meet with a shrunken gall-bladder, which is often quite difficult to demonstrate at operation.

The tumour that occurs is the result of gall-stones in the cystic duct, blocking its exit, accompanied by repeated attacks of acute cholecystitis. Such a combination of events may lead to a gangrenous cholecystitis, where the gall-bladder will not be greatly enlarged; or if it gives rise to less urgent symptoms the gall-bladder may enlarge fairly rapidly, after a few attacks, and form a considerable tumour in the right upper abdomen. These tumours may be so large that there may be difficulty in deciding whether it is a large kidney or gall-bladder.

Such a tumour when opened in the acute stage will frequently contain pus and stones, but no bile, and in the chronic stage mucus, but no bile. It is not uncommon to have a patient with a large gall-bladder and jaundice. You will remember that I have just said that a tumour only occurs as a result of gall-stones in the bladder, and earlier in the lecture that only occasionally does jaundice occur in connection with stones in this situation, and this jaundice is temporary and slight.

When jaundice occurs as a result of stones in the common duct you will find invariably that as a result of former attacks of cholecystitis, the stones having been originally in the bladder, the gall-bladder will be shrunken.

This is so constant that a law, known as Courvoisier's law, has been laid down and is one of the laws with no exception. "In cases of chronic jaundice due to blockage of the common duct, a contraction of the bladder signifies the obstruction is due to a gall-stone, a dilatation that the obstruction is due to some other cause," which cause is generally malignant disease of the head of the pancreas.

In such cases the enlarged gall-bladder contains bile. I will remind you of two other sequelæ of gall-stones, fistulæ and intestinal obstruction, but there is no time at present to deal with them.

There is another important point in connection with the operative treatment of cholecystitis, whether accompanied by gall-stones or not, and that is the advisability of removing the gall-bladder.

In many cases where there is a gangrene of parts of the gall-bladder or an empyema of that organ, it may be too dangerous or inadvisable to remove it; in that case you will sew a tube in, and allow the organ to drain, expecting it to become eventually converted into fibrous tissue with no secreting cavity left.

But in all other cases, where it is practicable, you must remove the gall-bladder, for if you only drain, in a large number of cases you will find that after a shorter or longer interval exactly the same symptoms that called for the operation will return and you will have to perform a second operation, when your difficulties will be increased by the adhesions following the first operation.

I have recently operated on a lady, the mother of an old Guy's man, who had gall-stones removed and the gall-bladder drained ten years ago. She remained quite well until eighteen months ago, since when she had frequent attacks of very severe abdominal pain, due to an acute cholecystitis so that her life became a misery. At the operation, which was not easy, I found an enlarged and tightly distended gall-bladder containing mucus and pus. I removed the greater part of the bladder, and she made a very comfortable recovery.

In the following case there was a very short interval between the operation for removal of the stones and the recurrence of symptoms due to the cholecystitis. I had removed the appendix of an elderly gentleman, and was exploring with my hand in the other parts of the ab-

domen, before closing the abdominal wall, when I chanced on a tight, distended gall-bladder, about double the size of the terminal phalanx of the thumb, with much adhesion of omentum to it. I was able to do no more than drain the organ owing to the patient's condition. Within two months he had a recurrence of his symptoms, due to an acute cholecystitis, which was relieved by the removal of the gall-bladder.

These cases of recurrence of symptoms after removal of stones is not at all uncommon; its explanation is easy. The tube in the gall-bladder drains the organ, and after a certain number of days comes away.

We hope that the gall-bladder has become converted into fibrous tissue with no secreting cavity; but unfortunately in many cases the hole in the fundus of the gall-bladder, through which the tube entered it, heals, and the gall-bladder reforms again in a more distorted shape than before. So that there is every probability of getting a recurrence of symptoms.

Obituary.

MARY LOUISE MORRELL.

We deeply regret to report the death of Nurse Mary Louise Morrell in Ireland on the 18th August, 1919, after a long illness contracted on active service.

Nurse Morrell joined the Q.A.I.M.N.S.R. early in 1917, and in December, 1918, she was invalided home from Salonika. Her life was sacrificed in the service of the sick and wounded.

Her funeral was conducted with military honours and attended by a large contingent of local ex-soldiers. The firing party from the 1st Dorsetshire Regiment, Derry, was present, and at the graveside fired three volleys.

Nurse Morrell was the elder daughter of Mr. S. Morrell, of Ballywildrick, Castlerock.

Guy's Hospital War Memorial.

	£	s.	d.
Brought forward ...	4,524	8	4
Dividend 5% War Loan	0	17	6
Thomas, H. J.	2	2	0
Lloyd, Vernon E.	2	2	0
DuBoulay, Herbert H.	3	3	0
Wedd, B. H.	5	0	0
Boswell, P. R.	5	5	0
Malcomson, G. E.	2	2	0
Metcalfe, G. H.	2	2	0
Pryce-Davies, J.	5	5	0
Rae, F. L.	5	0	0
Tyson, W. J.	2	2	0
Harrison, E. M.	2	2	0
Tanner, W. E.	5	5	0
Marshall, G.	5	5	0
Watson, J. L.	3	3	0
Wallace, F. H.	1	1	0
Cardin, Herbert	1	1	0
Strover, H. C.	1	1	0
Turner, P.	10	10	0
Lister, Thos. D.	5	5	0
Sheen, A. W.	2	2	0
Todd-White, A. T.	2	2	0
Bardswell, N.	2	2	0
Marsh, H. E.	1	1	0
Petley, F.	1	1	0
Gask, C. H.	1	1	0
Litchfield, P. C.	1	1	0
Begg, Edward	2	2	0
Terry, R. H.	1	1	0
Oates, J.	1	1	0
Mothersole, R. D.	10	0	0
Rowlett, A. E.	1	1	0
Ewing, A. W.	3	3	0
Allen, T. S.	1	1	0
French, R. E.	2	2	0
Clogg, A. H.	5	5	0
Baldwin, F. B. Judge	1	1	0
Ticehurst, N. F.	2	2	0
Symns, J. L. M.	2	2	0
	£4,636	12	10

Pass List.

University of London.

SECOND EXAMINATION. PART I.

L. Fogelman — T. A. Shaw
G. D. Shaw — H. J. W. J. Westlake
D. J. T. Jeans — H. J. Plowright
R. L. Waterfield

Society of Apothecaries of London.

August, 1919.

MEDICINE.—*C. W. Lakin.
FORENSIC MEDICINE.—G. K. Reeves.
MIDWIFERY.—C. C. Bennett.

* Has now completed the examination.

An Unusual Case of Hydronephrosis.

J. B., female, æt. 45, presented herself at Out-Patients complaining of a more or less continuous pain in the right hip for the past six months. For the same period she had noticed a swelling in right side of the abdomen which, on the whole, increased in size, but varied from time to time. She complained of no abdominal pain whatever. The patient was admitted to Martha Ward, under Mr. Fagge, on the 23rd August, 1919.

On examination.—A large and definitely cystic swelling was found extending downwards from the right hypochondrium. This swelling was fixed and appeared to be continuous with the liver, which was slightly enlarged. It was uniformly dull and crossed by no band of resonance. Nothing abnormal was felt per rectum. The conjunctivæ were slightly jaundiced, temp. 100; pulse 92; respiration 24. The patient had had no previous ill health, neither did she complain of any difficulty in micturition.

A provisional diagnosis of hydatid cyst of the liver was made. During the afternoon of the day following admission the patient began to complain of abdominal pain. This gradually increased in intensity; the pulse rate rose; the temperature fell, and the patient sweated profusely. At 8 p.m. the pulse was 144 and the temperature 97·4°. It was suspected that the cyst, which was still quite palpable, was leaking into the peritoneal cavity, and Mr. Davies-Colley decided to operate.

When the patient was placed on the operating table the abdominal swelling was found to have entirely disappeared; presumably the rupture was completed in moving the patient to the theatre. The abdomen was opened under warm ether and oxygen anæsthesia by a right paramedian incision. On opening the peritoneum several pints of clear straw-coloured fluid escaped. This fluid partly coagulated on standing and contained urea ·4 per cent. The collapsed cyst was found adherent to the right side of the second part of the duodenum and proved to be continuous with the pelvis of the kidney. The right ureter and renal vessels were ligatured and as much of the cyst wall as possible separated from surrounded structures and removed together with the main mass of the kidney which lay behind it. No calculi were found. The abdomen was closed, being drained both anteriorly and through a stab wound in the right lumbar region.

The patient was extremely collapsed after the operation, but her condition rapidly improved and has continued to do so up to the time of writing.

There are several interesting points about this case:—

1. The text-book criterion of renal tumour, *i.e.*, that it should be crossed anteriorly by a band of resonance (the colon) was falsified.

2. The hydronephrosis burst into the peritoneal cavity—a very unusual occurrence.

3. The hydronephrosis was pathologically atypical in that the kidney substance was not uniformly disposed around a distended pelvis. The dilatation appeared to be practically all pelvis. A small portion of kidney substance was spread around the pelvic origin of the cyst, but the major part of the kidney lay intact posteriorly.

4. The patient on admission complained of no abdominal discomfort. Her pain was entirely referred along the distribution of the external cutaneous nerve.

My thanks are due to Mr. Davies-Colley for permission to publish this case.

A. E. S.

Reviews, etc.

Short Notes and Mnemonics of Anatomy. By A. S. Irving. (E. & S. Livingstone.) 1s. net.

To burden one's memory with the entire collection of tag-ends contained in this little book would be hardly preferable to learning Gray off by heart. As the writer remarks, however, it is intended for students who have difficulty in remembering certain parts, and to such we can readily imagine it would at times be invaluable.

The mnemonics are nothing if not up to date. The time-honoured story of Timothy and the nervous housemaid is, of course, not lacking, while there are tales of flappers in offices, of staff sergeants and members of parliament, to say nothing of a harrowing story of four fat ladies who suddenly vanished while eating ices.

Catechism Series: Anatomy, Medicine, Physiology.

We have no great experience of these little books but they are doubtless a useful addition to text-books when revising a subject.

Leaves from a Medical Note Book

(1914—1918).

III. Typhoid Fever and Mixed Infections.

The difficulty of differentiating between typhoid fever and general miliary tuberculosis is fully recognised in the text-books. The co-existence of the two conditions is also mentioned by Osler. As an example of this rarity, and also of a thoroughly "mixed pathology," the following post-mortem report on a case dying during a typhoid epidemic seems worth recording :—

Martha T., æt. 31, a Belgian refugee, regarded as a case of typhoid fever during life, showed the following changes at autopsy :— Miliary tubercles in lungs; intimal tubercles in arch and descending aorta; miliary deposits in kidneys, together with infarction; miliary tubercles in spleen and suprarenals; tuberculous bronchial glands; mitral stenosis with left ventricular hypertrophy; adhesions between gall-bladder and colon; no active typhoid lesions, but B. typhosus was cultivated from the gall-bladder. Possibly the patient had been a "carrier" rather than an early or recovering case of typhoid fever.

This was only one of many instances of "mixed pathology" in Belgian refugees, among whom tuberculosis, rheumatic fever and round-worms would appear to have been very prevalent. Thus, in 19 post-mortem examinations the findings were as follows :—

1. Cerebro-spinal meningitis and pulmonary tuberculosis with cavity (age 33).

2. Typhoid fever and erysipelas (age 45).

3. Typhoid fever, and tertiary syphilis with advanced lardaceous disease (age 45).

4. Mitral stenosis and pneumonia (age 69).

5. Typhoid fever and streptococcal septicæmia from ethmoidal suppuration (age 65).

6. Typhoid fever and ascariasis (streptococci grown from spleen). (age 8).

7. Typhoid fever with perforation and old mitral endocarditis (age 14).

8. Typhoid fever and diphtheria (age 16).

9. Typhoid fever, diphtheria, coronary atheroma, and old mitral endocarditis (age 55).

10. Typhoid fever and diphtheria (age 12).

11. Paratyphoid B, old endocarditis, and chronic interstitial nephritis (age 68).

12. Miliary tuberculosis, mitral stenosis, and typhoid bacilli in gall-bladder (age 31).

13. Bronchiectasis, coronary atheroma, diphtheria, erysipelas, and parotitis (age 74).

14. Chronic pulmonary tuberculosis, tuberculous appendix, and typhoid bacilli in gall-bladder (age 57).

15. Chronic pulmonary tuberculosis, calculi and pyelonephritis, enlarged prostate, typhoid ulceration in ileum, ascariasis (age 70).

16. Typhoid fever, pulmonary tuberculosis, and gangrenous appendix (age 16).

17. Senility and retroperitoneal hæmorrhage (source unfound) (age 75).

18. Typhoid fever (age 6).

19. Typhoid fever and acute pleurisy (age 14)

Thus of 15 cases in which typhoid or paratyphoid infections were diagnosed, in only one was the typhoid fever the sole factor present to account for death.

In the four remaining cases there was a mixed infection of cerebro-spinal meningitis and tuberculosis in one, of diphtheria and erysipelas in one, and an association of pneumonia with old heart-disease in a third.

The cases in the hospital were of all ages and both sexes. The diagnosis of typhoid fever was in each instance based on clear bacteriological evidence or the presence of typical ileal ulceration or a combination of these. The notes of the autopsies were made in 1915; so far as can be recollected they do not represent any particular selection of cases.

That the majority of deaths occurred among sufferers from previous disease or at the extremes of life was, under the conditions obtaining at the time, to be expected, but the small proportion of deaths attributable to typhoid infection alone is perhaps noteworthy.

Diphtheria was always a very grave complication.

Extracts from the Letters of a London Medical Student.

(*Continued.*)

London, September 6th 1816.

. . . I am fully convinced now of the superior advantages in attending Brookes, and the Borough Hospitals together, not only as to the benefit derived from the exercise, which to one who has been accustomed to walk as much as I, is in my opinion necessary, but because Brookes pays more attention to us than Cooper possibly can. They have it is true a most splendid theatre, and an elegant dissecting room at St. Thomas', while Brookes' theatre is a poor one, and his dissecting rooms small and inconvenient, but this is not worthy of a thought, though Cooper's Anatomical pupils crack very much on it. For the last two days we have had no lecture at Brookes', he being very unwell. By the bye, I think it very practicable to visit the wards of the Hospitals daily. Though I have not entered, I see them now twice a week, and always attend on Fridays. I was there to-day, and saw a poor wretch with gangrene of the muscles on the anterior part of the neck, extending over the pectoral muscles for at least four inches below the clavicles, and superior extremity of the sternum. The ward smells worse than a dissecting room. Mr. Travers castrated an Irishman this forenoon at St. Thomas' who roared most lustily. He was to have performed the operation of hydrocele on a poor devil of a taylor, but he being frightened, I suppose, by the terrible outcries of the Irishman, would not get upon the table. Mr. Travers endeavoured to persuade him to undergo the operation, but in vain, and he accompanied his refusals with gesticulations, which gave such an effect to his pale, trembling, vacant, sartorial physiognomy, that the whole theatre were kept in a roar of laughter.

Another patient was brought and underwent the same operation without flinching. as might be expected; the taylor stood by and observed it, trembling in every joint, and when it was over slunk down stairs to his ward, amidst the laughter of the pupils, the hootings of the patients, who collected at the doors of the wards to see him pass, and the scolds of the nurses and sisters, The child on whom Mr. Travers performed the operation of lythotomy three weeks since, is dead, as might have been predicted. There are now three infants in one ward, with caries of the os femoris, in one of whom the disease extends from the condyles to the acetabulum. Two amputations have taken place this week, but as neither was performed on the regular day, and one indeed being an accident, was done at midnight, I witnessed neither of them. I hope times are getting better at Falmouth, and that this cold weather has had the effect of giving you something to do. How comes on your patient with fractured olecranon? The accident wards after Bartholomews, are full of fractures, luxations, contusions, etc., and I am astonished that so few accidents have taken place, when I consider the dangerous nature of the swings, etc. I passed through the fair yesterday, but did not remain in it a quarter of an hour.

(*To be continued.*)

Appointments.

R.A.M.C.

Maj. A. C. H. Gray relinquishes the acting rank of Lieut.-Col. on re-posting.

Lieut.-Col. E. W. Goodall relinquishes his commission and retains the rank of Lieut.-Col.

Special Reserve.

Lieut. F. K. Escritt to be Capt.

Territorial Force.

Capt. (Act. Lieut.-Col.) L. D. B. Cogan to be Assist. Director of Medical Services and to be Act. Col. whilst so employed.

R.A.F.

Dental Branch.—Lieuts. to be Capts.: H. L. Thorn, G. F. H. Bloom.

Civil.

G. W. Goodhart, M.B., B.C., to the Pathological Dept., University College Hospital.

Col. A. H. Tubby, C.B., C.M.G,. has been elected Prime Warden of the Blacksmiths Company of the City of London.

G. F. Haycraft, M.R.C.S., Honorary Ophthalmic Surgeon to Walsall General Hospital.

W. W. Cook, M.R.C.S., one of the Medical Referees under the Workmen's Compensation Act, 1906, for County Court Circuit No. 2.

A. Alan Forty, M.R.C.S., L.R.C.P., Medical Officer and Vaccinator, Hornton District, Banbury.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Guy's Hospital War Memorial.

SIR,—I understand there are several schemes before the War Memorial Committee. I beg leave to add yet another suggestion, that a memorial be placed in the Hospital Chapel, where many of the doctors and nurses we commemorate once sang and worshipped. There are two large arched recesses, one on each side of the altar, and I cannot think of a more fitting tribute to their memory than the filling in of these sombre recesses with two beautiful paintings and also placing two oak panels on which their names can be inscribed, thus keeping this memorial distinct from the panels on the right side of the chapel.

One essential of a War Memorial is that it should be of a permanent character, to keep fresh the memory of the heroic dead, and for this reason I beg the Committee to consider this proposal.—I am, Sir, yours faithfully,

A. E. POPHAM,
Chaplain (Temporary).

DEAR SIR,—A woman, who brought up her child to-day suffering from scarlet fever, asserted that she herself had had no less than six separate attacks of scarlet fever. On further questioning she stated that on each of these six occasions she had been admitted to a fever hospital, had been diagnosed as scarlet fever, and had subsequently desquamated. Does this constitute a record?—Yours truly,

VERNON LLOYD,
Out-Patient Dept.,
27th August, 1919.

Will the doctor who sent a card of enquiry about a microscope kindly write again, as the card has been mislaid?

Notice.

Royal College of Surgeons of England.

FIRST EXAMINATION FOR THE FELLOWSHIP.

Notice is hereby given that Surgeons, who have done commendable surgical work in connection with His Majesty's Forces during the War, may be admitted to the First Examination for the Diploma of Fellow on special conditions.

The conditions are as follows:—

1. The subjects of the Examination will be Anatomy and Physiology. The Examination will be partly written and partly *viva voce*; the questions asked will have a direct bearing on practical Surgery, and will not include morphology, embryology, histological or chemical methods. or practical examination in the use of the apparatus of the physiological laboratory.

2. A candidate must be a Member of the College, or a Graduate of Medicine of a University recognized by the College.

3. He must fill up a form of application provided for the purpose.

4. To this application should be attached evidence regarding his work from those under whom he has served.

5. The application, when submitted, will be considered by a Committee of the Council of the Royal College of Surgeons, which will decide whether it be granted or not.

6. In the event of the application being granted, the candidate will be admitted on one occasion only to the special Examination.

7. The first of these special Examinations was held in May, and the second will take place in November of the current year. A third special Examination will be held sometime in the year 1920.

8. Forms of application may be obtained from Mr. F. G. Hallett, O.B.E., Examination Hall, Queen Square, Bloomsbury, W.C. 1, to whom they should be forwarded when completed.

9. Candidates who wish to be admitted to the special Examination on 5th November, 1919, should submit their applications for admission at an early date, if possible, and in any case not later than 8th October.

S. FORREST COWELL,
Secretary,

Cricket.

Guy's Cricket Season, 1919.

Played.	Won.	Lost.	Drawn.
21	12	5	4

BATTING AVERAGES.

Name.	No. of innings.	No. of runs.	Times not out.	Highest score.	Avge.
C. Vincent Brown ...	17	758	2	101*	50·53
S. Rose	17	505	3	101	36·07
T. Wooldridge ...	15	428	2	107*	32·92
G. D. Shaw	12	338	0	76	28·16
D. M. P. Whitcombe	14	346	1	79*	26·61
E. H. Muir-Smith ...	5	101	0	36	20·20
H. A. H. Harris ...	15	262	2	50	20·15
L. B. Helder	15	261	2	51	20·08
F. J. Biddle	8	108	2	52	18·00
G. P. Lindsay ...	14	182	2	42	15·16

Examination Paper

For Pupil Midwives.

TIME ALLOWED—ONE HOUR.

All questions to be answered.

1. Differentiate between the meaning of the two following expressions used by Pupil-Midwives :—

(*a*) Bear-up, Mother.

(*b*) Bear-down, Mother.

At which stages of labour are they used?

2. Write as concisely as possible—

(*a*) The expressed thanks.

(*b*) The unexpressed thoughts of any Pupil-Midwife on receiving any of the following :—

(1) Geranium with pot.

(2) A large bunch of flowers.

(3) Many coloured table-centre.

(4) Aspidestra.

(5) Two eggs.

3. Describe as accurately as you can the appearance of a normal chest-of-drawers in Queen's Buildings. How many foreign bodies—

(*a*) Animate

(*b*) Inanimate

Can be put into one room 8ft. by 10ft.

4. (1) Is the passion for enlarged photographs confined to the Boro'? If not, where else may they be seen?

(2) What physiological or pathological defect would you expect to find in a Gamp who produced a safety pin after being asked three times for a jug of water?

Lawn Tennis.

GUY'S v. WALLINGTON.

Played at Wallington on August 30th. This game was very close. The result was not reached till the last match was being played. This was unfortunately lost. So we lost 4 matches to 5.

B. L. Laver and K. M. Woodruff (Guy's) lost to Smith and Dumayne, 1-6, 5-7; beat Speed and Wilson, 6-4, 6-2; beat Williams and Valentine, 8-6, 5-7, 6-4.

J. W. Schollum and G. D. Shaw (Guy's) lost to Smith and Dumayne, 2-6, 4-6; beat Speed and Wilson 6-0, 3-6, 7-5; lost to Williams and Valentine, 4-6, 7-9.

P. Krige and B. Keyter (Guy's) lost to Smith and Dumayne, 4-6, 6-3, 3-6; beat Speed and Wilson. 6-2, 4-6, 6-3; lost to Williams and Valentine, 6-2, 0-6 3-6.

On August 23rd, at Honor Oak Park, Guy' 2nd VI. beat the Nest-Anglo L.T.C.

Change of Address.

Stanley Wickenden, M.R.C.S., Greyhouse, Marshall Place, Perth, N.B.

E. Billing, M.R.C.S., Denholm, Chingford, Essex. (Tel. Chingford 157).

G. W. Goodhart, M.B., B.C., 24, Warwick Gardens, Kensington, W. 14.

Miss B. H. Daniels, Norfolk and Norwich Hospital, Norwich.

A. G. G. Plumley, M.B., L.D.S., 62, High Street, Oxford.

S. H. Coplans, L.D.S., P.O. Box 1833, Johannesburg, South Africa.

H. O. Long, from Ross-on-Wye, to Chedworth, Orleans Road, Hornsey, N. 19. (Tel. Hornsey 1847).

Capt. J. Stephenson, R.A.M.C., Oaklands West, Eltham Road, Lee, S.E.

Lieut.-Col. E. C. Hore, The Cottage, Amberley, Glos.

R. A. Rankine (late Surg. Lieut.-Commdr., R.N.), c/o Bank of New South Wales, Watt Street, Newcastle, Australia.

R. C. Matson, Capt. R.A.M.C., c/o Messrs. Holt & Co., 3, Whitehall Place, S.W. 1.

Capt. Reginald Curle, Old Studley, Wimborne Road, Bournemouth (permanently). (Tel. 342 Bournemouth.)

I. Tewfik, 45, High St., Rochester. (Tel. Chatham 231).

A. Alan Forty, M.R.C.S., L.R.C.P., Oriel Cottage, Shenington, near Banbury, Oxon.

Papers by Guy's Men.

Ralph Thompson, M.Ch., F.R.C.S.: A case of ectopia vesicæ.—*Brit. Journ. of Children's Diseases*, April–June, 1919.

Sir W. Hale White, K.B.E., M.D.: An address on some applications of experience gained by the war to the problem of civil medical practice.—*B.M.J.*, August 23rd, 1919.

R. W. Allen: Leucine—its occurrence and significance in the urine.—*Ibid.*

Lieut.-Col. A. W. Sheen, A.M.S., C.B.E., M.S.: Clinical observations in India during the war.—*Lancet*, August 16th, 1919.

Montague F. Hopson, L.D.S.: Presidential Address, British Dental Association, August 8th, 1919.—*Brit. Dent. Journ.*, August 15th, 1919.

W. H. Jewell, M.D.: Case of infiltration and ulceration of the vocal cords (previously shown).—*Proc. R.S.M., Sect. of Laryngol.*, July, 1919.

W. Kelsey Fry, M.C., L.D.S.: Prosthetic treatment of old injuries of the maxillæ.—*Ibid, Sect. of Odont.* July, 1919.

Capt. K. Black.—We regret that Capt. Black's name was erroneously spelt in the last issue (*Papers in the Indian Medical Gazette*, Feb., 1918).

Birth.

JOLY.—On August 10th, at Watford, the wife of James Moncrieff Joly, M.B., B.S. Lond., of Doom Dooma, Assam, of a son.

ED.—A. E. S.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 814.] SEPTEMBER 20, 1919. [SIXPENCE.

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Passim.

SOME months ago it was reported in the GAZETTE that the old appointment of "Clinical," which had been in abeyance during the war, was to be revived. Subsequently a notice was posted in the Colonnade inviting applications for this appointment. Many must have read the notice, but apparently few realised its importance, as nearly everyone at present in the wards knows nothing of the keen competition for this post in former days, and still thinks that on qualification a man will automatically step into a house appointment. Consequently, only two or three belated applications were received for one of the best appointments that the Hospital offers to newly-qualified or nearly qualified men.

In view of the apparent ignorance of the importance of doing Clinical, late applications for this post will be considered, and we have accepted the responsibility of bringing the facts to the notice of senior men.

Firstly, then, let us impress our readers with the fact that in the near future *no man will become House Physician or House Surgeon who has not previously done Clinical, Assistant House Surgeon, and Out-Patient Officer.*

Secondly, Clinical is, perhaps, the most interesting and instructive appointment in the Hospital. The take-in Clinical has the pick of any cases about to be admitted into the Hospital. Thus, every case in the Clinical ward is a "star" case, if we may use the expression. The Clinical makes his own investigations, thus having an opportunity of learning laboratory work first hand, and treats his own cases, under the guidance of the physician. Thus he gains experience of the diagnosis, treatment, experimental pathology, and bacteriology of both medical and surgical cases. Such an opportunity is not one to be carelessly cast aside.

Thirdly, let us point out that those who performed the duties of Assistant House Physician during the war will *not* be considered to have done "Clinical."

Lastly, let any reader ask old Guy's men their opinion of "Clinical." We are sure that their answer will be quite convincing. Any one who has done Clinical always affirms that it was one of the best, if not the best, appointment that they have ever held.

The Clinical wards will be Stephen and Esther. For the next three months Dr. Fawcett and Dr. Cameron will be the physicians in charge.

We earnestly recommend all senior men who are about to qualify to lose no time in applying for this most useful and interesting post.

IN a following column of this issue will be found another letter from Mr. Steward about the Biennial Dinner. It will be seen how great are the difficulties with which he has to contend, as at present so many Guy's men have changed their addresses recently, without having notified the hospital of their new address; and yet a great effort is being made to create a record in the number of attendances at the dinner. Therefore, every Guy's man who reads this paragraph, and has not as yet received a notice, is earnestly requested to communicate with Mr. Steward, and to make a special effort to be present at this dinner. Before the war, the attendance at the dinner was remarkably good, but it is hoped that this time the number will be at least doubled. Let every old Guy's man ask himself whether he can possibly so arrange matters that he will be free on the evening of October 28th, and if the answer is in the affirmative, let him lose no time in informing Mr. Steward of his intention to be present on that date.

ON another page of this issue a letter to the Members of the Ladies' Association will be found. It will be seen from this that the Association is full of potential energy for the coming year. Those of us who work in the Hospital very often do not realise the extraordinary amount of work which this Society does.

Its objects are, firstly, to provide clothes for the wards and necessitous patients; secondly, to visit patients in the wards; and thirdly, to support one or more beds in the maternity ward. The humility of the wording of the last mentioned object, as set down in the annual report of the Society, is striking to any who have been in Victoria and know that every one of the eight beds therein is supported by the Association. The work has been nobly carried on during the war, and last year the expenditure of the Association on the Hospital was £900. We wish the Guy's Hospital Association all possible success for the future, thereby echoing, we are sure, the sentiments of all connected with the Hospital.

EVERYONE is pleased to welcome Dr. Hurst back again to the Hospital. During the war we heard marvellous stories of the Seale Hayne Hospital, and all Guy's men were proud to think that the moving spirit of that world-famous institution was one of their number. The men in the wards are taking full advantage of Dr. Hurst's return, as shown by the large attendance at his Wednesday morning demonstrations.

We should also like to take this opportunity of expressing our gratitude to Dr. Johnson, who for the past few months has been holding similar demonstrations in the Neurological Department.

WE are very pleased to announce that Mr. John George Griffiths, C.V.O., has endowed "The Griffiths Demonstratorship in Pathology," in memory of his late wife Emily Wilhemina Griffiths. The post is held during pleasure for two years, and is renewable annually up to five years. The appointment is made upon the recommendation of a Staff meeting. It is a whole-time appointment, with an honorarium of £320 per annum. The Demonstrator is in no way confined as to his activity, but he must make Cancer Research his special duty.

It is difficult to imagine a more appropriate memorial. The Hospital, and, indeed, the whole community owe Mr. Griffiths a large debt of gratitude.

CONGRATULATIONS to Mr. J. E. Winston on his appointment as Hon. Sec. of the Incorporated Association of Hospital Officers, in succession to Mr. G. E. Pitt, late Secretary of St. Mary's Hospital.

THE instruments recently advertised in the GAZETTE by "Registrar" have now been disposed of.

The Biennial Dinner.

Dear Mr. Editor,

Every old Guy's man should have now received a notice regarding the dinner, but I fear that some of the notices will have gone astray, for it is difficult to be sure of the correctness of addresses, especially just at this time. If, therefore, any reader of this letter has not yet received a notice, I shall be obliged if he will send me a post card giving his correct address.

Readers of the GAZETTE can also in another way greatly assist me to make this dinner a record one, namely, by sending to me the name and address of any old Guy's man who they happen to know is at a temporary or new address, or, again, of any Colonial Guy's man who is temporarily in England.

I may mention that notices have not been sent to present Students, but all are invited to come to the Dinner, and particulars will be found posted in the library, the Students' Club, and the Colonnade, and forms of application for tickets may be obtained from the Librarian.

Finally, may I ask those who have not yet notified me of their intention to be present, to do so without delay, so that I may publish a very long list of acceptances in the next issue of the GAZETTE.

Yours sincerely,
F. J. STEWARD, Hon. Sec.

98, Portland Place,
W., 1.
September 18th, 1919.

Leaves from a Medical Note Book

(1914—1918).

IV. Kernig's Sign and Neck Rigidity.

The value of Kernig's sign as an aid to the diagnosis of meningitis is scarcely disputed. A failure to appreciate fully the characteristic features of the sign has, however, led to criticisms of its worth, and even to the making of wrong diagnoses.

During the war and particularly during those periods in which cerebro-spinal fever was epidemic, the differential diagnosis of acute meningitis from other febrile diseases showing headache, generalised pains and stiffness in back and limbs was of the first importance. Influenza, spirochætosis ictero-hæmorrhagica, and the more severe types of trench fever in their early phases were sometimes particularly difficult to distinguish from cerebro-spinal meningitis, and a failure to appreciate Kernig's sign seemed to increase this difficulty.

Some of the doubts in regard to the sign would appear to depend upon the descriptions in the literature, which are not always adequate—

"The sign consists in an inability to extend the leg fully when the thigh is placed at right angles to the trunk."—(Osler and McCrae's System.)

"Kernig's sign is then definitely present if the shank cannot be extended to within an angle of 45 degrees of the vertical line of the thigh." —(Worster-Drought and Mills Kennedy's "Cerebro-Spinal Fever.)

The first of these is true, and yet there are many conditions which may give a sign conforming to the description, though not a genuine Kernig's sign.

The second gives a useful working rule, but, again, is not wholly accurate.

The angle to which extension should attain would appear to have been much overstressed as a diagnostic point. The really important thing to recognise is not the quantity, but the quality of resistance to extension. In joint and muscular stiffness and pain and various febrile hyperæsthesiæ the resistance is an elastic one which with gentleness and suasion may be partially or wholly overcome. In acute meningitis, however, the resistance is almost invariably spasmodic, and both objectively and subjectively, on account of the pain induced, suggests to the observer the futility of further efforts to complete extension.

The visible tautening of the hamstring tendons is also more marked. The angle attained, however, varies from case to case, and in the same case from time to time. Again, in neck-rigidity the important feature is the stubborn, spasmodic quality of the resistance (even suggesting ankylosis), and not merely the degree of flexion obtained. It is also worthy of note that in both tests the pain is more severe, less localised to the muscles, and more acutely and distressfully reflected in the patient's face when meningitis is present.

Two Cases of Intestinal Obstruction.

CLINICAL LECTURE BY MR. PHILIP TURNER.

GENTLEMEN,—The two cases of intestinal obstruction which form the subject of this lecture were seen at a military hospital in France. Though the cause of the obstruction was different in each, they present several features in common, viz., that in both the patient was under treatment at the time for other injuries of a severe nature, that the cause of the obstruction was independent of the injury, and that the obstruction developed while the patient was undergoing treatment in bed and was apparently doing well. Though it is very unusual for acute forms of obstruction to appear under these circumstances, I can recall several other cases of this nature, two of which were hernias which became strangulated while the patient was in bed undergoing treatment for some totally different condition. One of these was a woman who was quite unaware that she had a hernia until it was found on examination after strangulation had taken place, and the other was an old gentleman, who had had a hernia and had worn a truss for many years, in whom strangulation occurred two days after an operation for cataract.

Generally it is difficult to explain in these cases exactly what determines the onset of the obstruction while the patient is at rest in bed, though the actual cause may have been present for a very long time, or even be congenital. In a few cases, such as the first described below, it is possible to recognise some strain which is a fairly obvious explanation of the onset.

In these cases the diagnosis of obstruction may be difficult and it may be impossible to recognise the actual cause until the abdomen is explored at an operation. The patient is already under treatment for some other trouble, possibly of a serious nature, and the natural tendency is for one to endeavour to make the new symptoms fit in with the original disease or with some likely complication of it; or, again, the symptoms of the original disease may mask and render obscure the symptoms of obstruction. In either case valuable time may be lost.

The prognosis is likely also to be adversely affected, for the original disease or injury, if severe, or of long duration, will have so weakened the patient that the likelihood of his standing the operation necessary for the relief of the obstruction is greatly diminished. This is seen in both of the cases described below. In the first, the prolonged suppuration and sloughing of a severe compound fracture of the femur had rendered the patient unfit to stand any severe operation and was, without doubt, largely responsible for death; while in the second, though the operation was of a more severe character, the fact that the man was suffering from multiple wounds, and a few days before had a moderately severe secondary hæmorrhage certainly contributed to the fatal result.

CASE 1.

Corporal C. was admitted to hospital on January 20th, 1916, having been run over by a motor lorry which passed over the right thigh and the left foot. There was a lacerated wound about three inches in length in front of the right thigh near the apex of Scarpa's triangle, and there was an obvious fracture of the shaft of the right femur. The left foot was also lacerated, but there was no fracture, and this wound gave no further trouble. There was no sign or symptom of any abdominal injury, but in the right iliac fossa there was the scar of an appendix operation which had been performed five years before. An X-ray examination showed a comminuted fracture of the shaft of the femur just below the small trochanter. An anæsthetic was administered the day following, the wound cleaned, a loose piece of bone removed, and the leg put up on a Thomas's splint. During the next few days the whole thigh became extremely swollen and a gangrenous patch appeared in the skin on the outer side. An anæsthetic was given on two occasions and free incisions were made for drainage. It became obvious that the wheel of the motor must have pinched up the skin of the thigh, tearing it away from the deep fascia most extensively. Blood had collected in this space with the result that there was a hæmatoma of enormous superficial extent which was infected and suppurated. The patient's condition became very serious, and amputation, which would seem to have been most desirable was rendered impossible owing to the suppuration and stripping up of the skin having extended

upwards into the gluteal region well above the tuberosity of the ischium. With this, and as the result of the separation, there was extensive sloughing of the skin as well as, in the front of the thigh, of the deep fascia. By February 5th a wide area of skin had sloughed extending from the outer side at the level of the anterior superior spine, obliquely across the front of the thigh to the inner side just below the level of the knee. In addition there was a large pouch behind where the skin was separated, and another one above extending into the gluteal region. Strange to say the deep suppuration around the fracture was not severe. The leg now presented a most extraordinary appearance, about half of the skin of the thigh having sloughed away and the muscles of the front, owing to sloughing of the fascia, being exposed much as in a dissection. A Balkan support had been fitted over the bed so that the patient was able to raise himself; he was suspended from this by a sheet under his back for the dressings, which were lengthy and had to be done twice a day. On February 15th an abscess in the left calf—not directly due to the wound—and probably pyæmic in origin was opened. During this time the patient had been extremely ill, but for the next two weeks he made rapid and steady progress. By the end of February suppuration had practically ceased, the large wound was granulating satisfactorily, and it looked as though skin grafting would eventually be possible. There had been no complaint of abdominal pain, no vomiting, and the bowels had acted well and regularly. On the night of March 4th there was some abdominal pain, with retching, and he vomited once. The pain came on in attacks and was relieved by pressure; it was referred to the epigastric region. He was given Mist. Bismuthi et Ammon. Cit. and was considerably relieved, though the symptoms recurred on March 5th. As the bowels had not acted for two days an enema was given with a small result, but the patient felt better, the pain was much less, and there was no vomiting for some hours. The improvement was continued on the following day, March 6th, but he vomited small amounts of bilious fluid on two or three occasions in the evening. Up to this time nothing abnormal could be felt in the abdomen, and there was no tenderness on pressure about the old appendix scar. The temperature was subnormal and the pulse rate which had been over 100 since his admission had not risen. He had been on ordinary diet, and it was thought that the symptoms were most probably due to gastritis, but possibly to some pyæmic infection of the peritoneum. On the morning of the 7th the patient was worse, the vomiting was more frequent, and on one occasion he brought up about three-quarters of a pint of brown fluid. There was some abdominal distention, and distended coils could be felt, chiefly in the epigastric and umbilical regions; nothing could be detected in the right iliac fossa. There was also a little visible peristalsis. It was now certain that there was definite organic obstruction, but the cause of this was uncertain. It was difficult to see how it could have been caused by the injury, and in view of the old appendix trouble it was thought that it was most probably due to some contracting adhesions the result of this.

The operation was performed upon the same day, March 7th. The abdomen was opened in the mid line. As soon as the peritoneum was opened a little fluid escaped and distended coils of small intestine presented in the wound. The transverse colon could not be found, and it was thought that it was probably empty and displaced upwards in the abdominal cavity. The distended small intestine was next displaced from the pelvis in order to ascertain the condition of the termination of the ileum. This was empty, and on tracing it upwards to reach a distended part of the gut it was found to lead to an empty and contracted piece of large intestine, assumed to be the pelvic colon, tightly bound down in the pelvis. It was found that the small intestine with its mesentery here passed through the mesentery of the large intestine, both being tightly bound together. On pulling on the contracted part of the small bowel the termination of the ileum and the cæcum were brought into view, proving that the appendix had nothing to do with the obstruction. The opening in the mesentery of the colon was now enlarged and the dilated small intestine gradually drawn down through the opening. As this was done, the coil of large intestine gradually rose from the pelvis and proved to be the transverse colon. It soon became obvious that practically the whole of the small intestine had passed through an aperture in the transverse meso-colon between the stomach and the colon, curving over the latter and forcing it to the lower part of the abdominal cavity. When reduction was complete the situation of the aperture and the

nature of the obstruction were readily seen. The edges of the opening were drawn together with a few stitches; a distended coil was incised to allow gas and fæcal matter to escape and after this incision had been closed, the intestines, which, though congested and dilated, were nowhere gangrenous, were returned to the peritoneal cavity. A drainage tube was inserted and the abdominal wound closed. The patient was infused during and after the operation, but his condition was very serious, and he died some twelve hours later.

The condition was thoroughly investigated at the post-mortem examination. All obstruction was relieved, but the line of constriction could be seen ten inches above the ileo-cæcal valve. There was an opening in the mesentery of the transverse colon just to the left of the mid-line, curving to the right above where it had been incised and sutured. The untorn left and lower margins were well-defined, thick, and evidently of old standing. The right margin which had been cut through at the operation was formed by a definite, thick, fibrous band extending up from the duodeno-jejeunal flexure into the transverse meso-colon. On passing a finger of one hand through the opening and a finger of the other hand through the foramen of Winslow it was found that they were separated by a fold of peritoneum extending from the posterior surface of the stomach to the pancreas and spleen. Hence the great omentum and the transverse meso-colon were adherent and the lesser sac shut off.

Apertures in the mesentery are often very difficult of explanation. Occasionally they are the result of injury, the edges healing, but the centre of the tear remaining open. In other cases they are apparently of congenital origin, or are due to absorption taking place at the side of some band often formed by an obliterated vessel. The latter is probably the explanation of some of the perforations of the lower part of the mesentery of the small intestine the absorption taking place to the side of the obliterated vitelline vessels. In the present case the absence of any abdominal symptoms after the injury and the absence of any abdominal signs, though these were sought for together with the long interval (six weeks) before any abdominal symptoms developed, strongly suggest that the aperture was not of traumatic origin. This was confirmed by the findings of the post-mortem, especially the fact that the lesser sac was shut off, the lack of any sign of recent injury, the thick definite margins, and the well-marked ligamentous band to the right. These all point to the opening being of very long standing and probably congenital. In this connection it would have been interesting to know the symptoms which led to the appendicectomy and the condition of that structure when removed.

As regards the actual cause of the onset, I think that there is very little doubt that this was due to the contraction of the abdominal muscles associated with the patient lifting himself by the Balkan support. It is possible that a coil of intestine had for a long time projected through the opening and had become accustomed to this position, but that the effect of the unaccustomed muscular action was to force through the remainder. The sub-acute onset of the obstruction is in favour of this view.

CASE 2.*

Private M., aged 37 years, was admitted to hospital on August 27th, 1917, suffering from multiple shell wounds received two days before. Most of the wounds were comparatively trivial and superficial lacerations of the legs, but there was one fairly extensive wound of the right loin. This had been excised at a Casualty Clearing Station, treated with B.I.P., and sutured. On admission the general condition was quite good, but he complained of pain in the region of this wound and shortly after admission the temperature was found to be 103·5°. The dressing was accordingly changed, and a red, tense, sutured wound was found extending from just below the highest point of the right iliac crest upwards and forwards to about the tip of the ninth rib. The stitches were removed, when a considerable amount of pus and B.I.P., escaped and the wound gaped widely. The upper three-fourths of the wound were found to be superficial, but below the muscle had been penetrated, though apparently not deeply. There was no abdominal pain or tenderness, the bowels had been acting well, there had been no vomiting, and the abdomen appeared to be quite normal on examination. The wound now cleaned up well, and the patient made good progress until September 8th, when there was a brisk secondary hæmorrhage. An anæsthetic was given and the wound ex-

*This case was set as the case for commentary at the examination for the Treasurer's Gold Medal for Surgery, 1919.

plored, but no definite vessel was found beyond one or two muscular branches, which were secured and the wound packed. No track extending deeply into the muscle could be found.

There was no further bleeding, and the patient continued to do well until I was asked to see him again on the evening of September 13th. The history was that for the past three days he had suffered from occasional attacks of vomiting, bringing up small quantities of bilious fluid. The bowels had acted naturally on September 11th, but as there had been no motion since, an enema had been given on the morning of the 13th with a small result. There had been no abdominal pain, and as the pulse rate had not risen and the temperature was normal, no particular attention was paid to the vomiting, especially as a number of the other men in the same ward were suffering from mild gastro-enteritis.

The following points in the previous history were elicited: The patient had for many years been subject to "bilious attacks." These usually lasted for about 24 hours; there was vomiting and sometimes slight vague abdominal pain referred to the umbilicus. He considered that the present attack was of the same nature, but said that he had never had such a troublesome one before. On examination of the abdomen there was no distention, and there was good movement on respiration; there was no pain, tenderness, or rigidity; palpation was easy and nothing abnormal could be felt. Heart, lungs, urine and temperature were normal; the pulse rate was 90. As there had then been no vomiting for eight hours, Ol. Ric. 1 oz. was ordered, and as it was not definitely known that the missile had been removed, an X-ray examination was also considered advisable. This was carried out on the following morning, but no metal fragment or other abnormality could be detected. Though the Ol. Ric. had not acted and the bilious vomiting had re-commenced, the patient declared that he felt better than on the day before. He had, however, for the first time had some vague pain referred to the umbilicus, and the pulse rate was 106, whereas it had never before been above 100. On examination of the abdomen, though there was still no rigidity and nothing abnormal could be felt, it appeared to be slightly distended, and after palpation slight visible peristalsis was noticed just below the umbilicus. On these grounds operation was decided upon and a laparotomy was performed on that day, September 14th.

The abdomen was opened in the mid-line below the umbilicus. On incising the posterior layer of the rectus sheath there was a gush of milky purulent fluid. Though I did not think I had reached the peritoneum it seemed most likely that the retro-peritoneal tissue was deficient and that the fluid was pus escaping from the peritoneal cavity. However, on mopping it away it was seen to come from a cavity lined with mucous membrane, presumably a piece of adherent intestine. The rectus sheath and peritoneum were accordingly incised at the upper end of the wound and the peritoneal cavity opened. A finger introduced through the opening soon showed the true state of affairs, viz., that there was a Meckel's diverticulum attached to the umbilicus. This was fully exposed and its distal extremity freed. A fibrous band accompanied the diverticulum and the proximal end of this was attached to the mesentery crossing the lower end of the ileum and compressing this opposite the attachment of the diverticulum. While investigating this there was a sudden gush of fluid fæcal material, and on drawing the ileum and diverticulum through the abdominal wound it was seen that there was a gangrenous area opposite the line of compression which had given way. The intestine was now clamped above and below, and the diverticulum with two or three inches of intestine on each side of it were excised and the divided bowel afterwards united by a lateral anastomosis. The patient was infused during the operation and at the conclusion had a very fair pulse, but some time after collapsed and died about six hours after his return to his ward. No cause for death was found at the post-mortem examination, but I believe that the multiple wounds and the hæmorrhage had lessened his vitality and thus contributed to the fatal result.

The diagnosis of this case was of considerable interest. The signs and symptoms all pointed to an organic obstruction rather than to suppurative peritonitis either localised or general. The question, of course, arose as to whether the abdominal trouble was the result of the wound, but after consideration of the history and the result of the various examinations of the wound and the abdomen this could be fairly certainly excluded. The history extending over many years of "bilious attacks," suggested that the cause of the obstruction was of long standing and possibly congenital and might be a band, contracting peritoneal adhe-

sions, a Meckel's diverticulum, or an internal hernia. I have pointed out elsewhere* that a long history of "bilious attacks" associated with bilious vomiting and dragging or colicky pain at the umbilicus may enable one to suspect rather than actually to diagnose in some cases the presence of a Meckel's diverticulum, and such proved to be the case here. Why, after being present the whole of the patient's life, and not having given trouble during two years of strenuous military service, obstruction should occur while the patient was lying in bed and not subject to any strain is a fact of which I can offer no explanation.

A final point is that in both these cases the onset of the obstruction was more gradual than is usual with these particular causes. This was doubtless partly due to the fact that in both the actual cause was of long standing and that the intestine had accommodated itself to the presence of the abnormal structure, and also partly to the conditions under which the obstruction arose, viz., that the patient was at the time confined to bed.

*Three Cases of Persistent Meckel's Diverticulum. Guy's Hospital Reports, vol. lxv., p. 38.

List of Interesting Cases in the Wards.

MEDICAL.

Miriam, 4, 6, 8, 14.—Summer diarrhœa—intoxication.
Addison, 7.—Ulcerative colitis.
13.—? G.P.I.
22.—Paralysis agitans.
48.—Splenic anæmia.
Mary, 22.—Ptomaine poisoning.
Esther, 9.—Paroxysmal tachycardia.
18.—Splenic anæmia.

SURGICAL.

Martha, 18.—? Osteo-sarcoma of pelvis.
Lazarus, 4.—Unilateral varicose veins—? growth in pelvis.
13.—Old plating of femur—separation of plate.
16.—Tic douloureux.
Naaman, 17.—? Syphilitic osteitis.
Dorcas, 21.—Tubercular elbow.
19.—? Fibro-sarcoma of thigh.

What are you doing on the 28th of October? Going to the Guy's Biennial Dinner, of course.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—In to-day's number of the GAZETTE Dr. Vernon Lloyd tells us of a woman who claims to have had six attacks of scarlet fever, and he asks if this does not "constitute a record."

It is very doubtful whether she was really suffering from true scarlet fever, and a more likely explanation is that her rash was the so-called "recurrent, desquamative, scarlatiniform erythema." I have recently seen a few of these cases, and it is important that the condition should be recognised, for the diagnosis from mild scarlet fever may be difficult.

An erythema very like that seen in scarlet fever may, of course, represent a reaction to various toxins, *e.g.*, some drugs such as mercury, quinine, belladonna, chloral and picric acid, food-poisons, and bacterial toxins, particularly those of certain strains of streptococci. Sometimes desquamation may follow such an erythema, but the diagnosis from scarlet fever is not as a rule difficult, since there is little or no pyrexia, sore throat and circumoral pallor are not usually seen, and the pulse-rate may be normal or only slightly raised.

But there is a group of cases for which the name "recurrent, desquamative, scarlatiniform erythema" should be reserved, and it is in these cases that a diagnosis of scarlet fever is nearly always made.

The main points in the differential diagnosis are as follows:—(1) Although the fauces may be injected and the tonsils inflamed, the patient does not complain particularly of sore throat. (2) The temperature is only slightly raised as a rule. (3) The pulse-rate is not markedly quickened. (4) Desquamation begins early before the erythema has begun to fade. (5) Although the mucous membrane of the tongue may desquamate, the typical "strawberry" appearance is not seen. (6) There may be a history of one or more similar attacks. (7) The rash may or may not involve the face; if it does, there may be œdema of the nose and cheeks, but circumoral pallor is not marked.

The ætiology of these cases is a matter of dispute. Those I have seen have all had septic tonsils, and I regard the attacks of erythema as anaphylactic reactions to a hæmolytic strain of streptococcus, the focus of infection being usually, if not invariably, the tonsils.—I am, Sir, yours very truly, H. W. BARBER.

7, Devonshire Place, W.
Sept. 6th, 1919.

SIR,—May I bring before your notice certain statistics which point to a condition of affairs which needs a remedy?

In October term, last year, there were about 50 new students, approximately the normal number. But in January and June of this year there were about 200 more new entries. And now for the October term

already 170 are on the waiting list. With such a large number of new students individual attention of any sort is practically impossible, and the laboratories are so crowded that one might almost fancy one was at a tube station at about 6 o'clock in the evening! For one who has been absent on active service during the greater part of the war it is particularly difficult to prepare for an examination under these conditions.

The lecturers and demonstrators, also, must feel, when the normal number of students has been trebled or quadrupled and the staff and accommodation has remained as before, that they have a task before them with which they are unable to cope.—I am, etc.,

Guy's Hospital, "DEMOBBED."
16/9/19.

Guy's Hospital Ladies' Association.

To Members of the Guy's Hospital Ladies' Association,

May I call your attention to the pressing need, this year, for greatly increased activity by all members of the Guy's Hospital Ladies' Association? During the war the work has naturally somewhat decreased owing to many anxieties and the demands made upon our time by war work of various kinds.

In this time of reconstruction the strain upon all hospitals is very great, and I hope that the Ladies' Association will be able to take a large part in supplying the urgent needs of Guy's.

I feel sure that I can rely upon the help of all present members in this special work. This can be given in three ways:—

1. By securing new Honorary or Working Members.

2. By increased efforts of members themselves to carry out the objects of the Association, not only by subscribing, but also by either attending the working parties or by sending garments, as provided for in the Rules of the Association.

3. By trying to form new Branches.

During the war it has obviously been impossible for many working members to send garments owing to the urgent claims of the soldiers. I trust that in the future members will again contribute their two garments.

This next season, Working parties will be held fortnightly at different houses on Wednesdays, and in the alternate weeks on Fridays at Mrs. Fawcett's House, 66, Wimpole Street, W., 1., the hours will be 2.30 to 4.30 p.m. Tea will be provided at the end of the meeting.

Members' Visitors are always welcome at the working parties.

Working party members have been very scattered during the war, though those at liberty to attend meetings have shown great devotion.

Would you be so kind as to send your subscription, which is due on October 1st, to the Hon. Secretary, Mrs. Philip Turner, 73, Wimpole Street, W. 1., who will also answer any inquiries.

Yours very truly,
MABEL BONSOR, Chairman.

38, Belgrave Square,
S.W., 1.
September 15th, 1919.

Guy's Hospital War Memorial.

	£	s.	d.
Brought forward ...	4,636	12	10
Humphreys, F. R.	1	1	0
Huckett, E. S.	1	1	0
Quesada, R.	2	2	0
Cowles, Hector C.	1	1	0
Coombs, C. G.	1	1	0
Mitra, B.	1	1	0
Kinsey-Taylor, A. E.	5	0	0
Adams, Sidney	2	2	0
Doll, H. William	2	2	0
Achner, C. A.	5	5	0
Young, W. A.	1	1	0
Leblanc, F. R.	1	1	0
Lipscomb, E. H.	2	2	0
Smith, Philip	2	2	0
Hilton, C. T.	2	2	0
Alexander, S. R.	2	2	0
Dixon, G. F.	5	5	0
Tonkin, B. Moorwood	2	2	0
Kingham, R. V.	1	1	0
Danby, A. B.	3	3	0
Webster, V. T. P.	2	2	0
Turner, F. M.	5	0	0
Dreaing, H. G.	5	5	0
Flower, N.	3	3	0
Stewart, H. M.	2	2	0
Bubb, Charles H.	10	10	0
Richardson, Horace	2	2	0
Edwards, Francis H.	5	5	0
Reynell, W. R.	2	2	0
Millett, H.	5	5	0
Brown, Miss W. M.	1	1	0
Gibson, J. H.	2	2	0
Greenwood, A. Atkins	1	1	0
Ormond, A. W.*	26	5	0
Penny, E. A.	2	0	0
	£4,755	14	10

*Balance of total donation of £52 10s.

Honours.

Royal Navy.

O.B,E. (Military Division.)

Surg. Lt. H. C. Mann. Surg. Lt. H. F. Percival.
Surg. Lt. G. Nunn. Surg. Lt.Com. R. A. Rankine.
Surg. Lt. E. G. Slesinger. Surg. Com. A. R. Thomas.
Surg. Lt. Com. (Act. Surg. Com) W. K. Wills.

The names of the following Naval Medical Officers have been brought to the notice of the Admiralty for valuable services in the prosecution of the war:—

Surg. Lieuts. F. C. Endean, F. G. Newman.
" T. Norman, A. H. Crook, M.C.

T.F. Decoration.

H.M. the King has conferred the Territorial Decoration upon the undermentioned officers:—

Lieut.-Col. E. B. Dowsett, R.A.M.C.(T.F.)
Lieut.-Col. J. A. Masters, R.A.M.C.(T.F.)

Guy's Hospital Past and Present Nurses' League.

After an interval of five years the opening meeting of the Nurses' Swimming Club was held on Wednesday evening, August 27th, in the Hospital Swimming Bath. There was a large number of entries for the tournament; spectators crowded every corner of the floor space or ledges, and several ardent supporters nearly joined the competitors in the water. Among the items on the programme was a fancy dress race, in which a golliwog became transformed into a streaky magpie; a "uniform" race, in which collars, caps and aprons went on at lightning speed with queer angles, and a "diving competition." During the evening a "visitor" fell into the water at the deep end and was gallantly rescued by Nurse Porter. The prizes were presented to the winners by the Matron, as follows:—

Long Distance Race "A" badge.—(1) Nurse Banks; (2) Nurse Cornwall.

Long Distance Race "B" badge.—(1) Nurse Pughe; (2) Nurse Courtenay.

Uniform Race.—Nurse Cornwall.

Fancy Dress.—(1) Nurse Banks; (2) (Special Prize) Nurse Hunt.

Diving.—Nurse Cornwall.

Sister MacManus, Sister Lazarus and Sister Patience kindly acted as judges.

The Nurses' Photographic Society also opened its winter session on Tuesday, September 9th, and it is proposed to give a series of practical demonstrations on "photography as a hobby" to those who wish to know more about the subject, and to arrange for some lantern lectures on interesting topics.

Another society which is busy looking up its members is the Nurses' Dramatic Society, and we look forward to them to provide us with an enjoyable evening shortly.

The Nurses' Choral Society has had several practices, and is in full swing.

Pass List.

University of London.

M.B.—SECOND EXAMINATION. PART I.

July, 1919.

W. R. Spurrell.

FIRST EXAMINATION.

July, 1919.

*T. S. Blacklidge.	H. N. Hearle.
L. W. Cann.	†G. O. Mitchell.
R. J. Cann.	P. M. Moffatt.
R. S. Chambers.	A. T. W. Powell.
G. F. Gibbard.	W. G. Sears.
E. J. Greenwood.	J. L. le C. Walker.

*Distinguished in Inorganic Chemistry.
†Distinguished in Physics.

Children's Dental Department.

THE appointment of a Fifth Assistant Dental Surgeon to whom shall be assigned as chief duty the control and general superintendence of a Children's Dental Department.. has recently been made.

The urgency of this appointment is due to the necessity—

(a) Of dealing more effectively with the needs of children attending for Dental Treatment.

(b) Of instructing Students more thoroughly in the treatment of children.

At the moment, dental treatment as accorded to children in the Dental Department is largely confined to such attentions as can be rendered in the Extraction Rooms or in the Orthodontic Department. Chiefly owing to lack of accommodation and to difficulties in the arrangement of adequate service, the most important problem, that of the treatment of caries of the temporary teeth, has not received the attention which its importance demands.

In the immediate future, as is well understood, a considerable addition to the number of qualified dentists holding office under the Public Health Medical Service, especially under the Board of Education, will be called for.

Heretofore no special measures have been devised at Guy's Hospital for equipping men for the particular duties which the holding of such appointments involves.

The extension of the benefits of dental treatment to a larger number of children will, it is hoped, by affording to the student the opportunity of familiarising himself with the handling of these young patients, serve in some degree to make good this omission.

The Assistant Dental Surgeon will attend on Wednesday and Saturday mornings, and will have charge of all children up to twelve years of age, and of all Orthodontic cases irrespective of age.

He will correspond with the Physician-in-charge of the Children's Department.

The Dental Department for Children, until such time as better provision can be made, will be accommodated in the present existing buildings. It is proposed that on fixed days and at stated times a certain number of chairs shall be reserved in the Conservation Room for occupation by the children attending.

Operations involving the extraction of teeth will be conducted in the rooms at present devoted to such purposes.

Papers by Guy's Men.

Rolph Creasy, M.R.C.S., L.R.C.P.: Vesical Papilloma Simulating Vesical Tuberculosis.—*Lancet*, Sept. 13th, 1919.

Norman Bradly, M.D.: Case of Stomach and Bowel Atony.—*Lancet*, Sept. 6th, 1919.

N. I. Spriggs, M.D., F.R.C.S.: A case of Nerve Transplantation.—*Ibid.*

John Ryle, M.D. Lond., M.R.C.P.: Trench Nephritis.—*Medical Record* (New York), August 9th, 1919.

R. G. P. Lansdown, M.D., M.R.C.S., Major R.A.M.C.(T): The systematic examination of the abdomen.—*Bristol Medico-Chirurgical Journal, Summer Number*, 1919.

Extracts from the Letters of a London Medical Student.

(*Continued.*)

London, March 28th, 1817.

. . . . In the hospitals there is nothing particularly new. Curry has been confined with gout for nearly two months, and the course being behind hand, Babington lectures on Thursday evenings, so that every evening is quite occupied. In practice the Nitro-Muriatic Acid Lotion has very recently been introduced in sloughs and sloughy sores, particularly in those indurated ones which sometimes supervene on chancre or bubs, under the excessive action of mercury, of which we have lost some patients this session. It is found to be at least equal, and probably superior to the Nitrous Acid Lotion. Two very bad cases in particular of extensive sloughings of the Mons Veneris and adjacent parts have quite healed under its application. The proportion used is Acid. Mur. qtt x 4, Acid. Nit. qtt x x. A month since, a dresser in examining the arm of a man who died of inflammation of the vein following bleeding, cut his finger. The axillary glands were enlarged the following day, and he is since dead. We have lost four students this season, one of them a nephew and apprentice of Cooper's. A fifth is not expected to recover. I am now dissecting part of a female subject. Wonderful to relate, though 28 years of age, her hymen was perfect. A handsome woman, too. I gave it to Brookes at his request to place among the rareties of his Museum.

Appointments.

R.N.M.S.

Surg. R. A. Rankine, O.B.E., has been allowed to withdraw from the R.N.M.S. with a gratuity.

R.A.M.C.

Lieut. G. C. Robinson to be Captain.

Late Temp. Capts. to be Captains.—E. Duke, E. S. Hall.

Capt. R. G. Oram to be Acting Major whilst specially employed.

Capt. (Act. Maj.) G. W. C. Hollist relinquishes acting rank on ceasing to be specially employed.

Special Reserve.

Lieut. S. A. Withers to be Captain.

Territorial Force.

The undermentioned officers relinquish their acting rank on ceasing to be specially employed:—

Capt. (Act. Lieut.-Col.) J. Young, D.S.O., relinquishes acting rank of Lieut.-Col.

Capts. (Act. Majors) G. F. Willan, D.S.O., G. H. H. Manfield, J. J. E. Briggs, O.B.E.

R.A.F.

Lieut. E. H. L. Le Clezio to be Captain.

Change of Address.

Capt. E. A. Leviseur, from 1st South African General Hospital, B.E.F. to c/o M. Leviseur, Esq., Bloemfontein, O.F.S.P.

F. L. King, Arran, Blake Hall Road, Wanstead, E. 11.

Arthur F. Hurst, M.D., F.R.C.P., 17, Devonshire Street, Portland Place, W.

A. B. Danby, c/o Junior Army and Navy Club, Horse Guards Avenue, Whitehall, S.W.

J. S. Wright, L.D.S., 35, Nottingham Place, W. 1 (Tel. Mayfair 3970).

Capt. E. A. Penny, I.M.S., Queen's Cottage, Swanage, Dorset.

H. P. Price, from H.M.S. Lion to St. Clair, Ticehurst Road, Reading (Tel. 1264).

Capt. W. E. Watson, R.A.M.C., 12, De Pary's Avenue, Bedford (Tel. 111).

Capt. R. W. Cushing, R.A.M.C. (T.F.), Montana, Eversfield Road, Reigate, Surrey.

F. Heatherley, F.R.C.S., Ministry of Pensions, 1, Albion Street, Ashton-under-Lyne.

L. Muir-Smith, late Major R.A.M.C. from Caucasia to 8, Upperton Road, Eastbourne.

Guy's Hospital.

Standing Orders for the Griffiths' Demonstrator of Pathology.

1. The Griffiths Demonstrator of Pathology is appointed by the Treasurer upon the recommendation of a Staff Meeting, and holds office during pleasure for a period of two years, renewable annually up to five years. He must possess a registrable qualification to practise.

2. The honorarium attached to the Demonstratorship is £320 per annum, payable quarterly in arrear.

3. The Demonstrator shall be under the control of the Clinical Research Committee of the Medical School, and shall assist in the teaching of Pathology. He is required to devote the remainder of his time to the prosecution of Research. He shall present annually to the Clinical Research Committee a report stating in detail the nature of the Investigations upon which he has been engaged. While not confining his duties to Cancer Research, he shall make the pathological study of Cancer his special duty.

4. The Griffiths Demonstrator shall not hold any office or appointment, or carry on any business or profession which, in the opinion of the Clinical Research Committee, prevents him from devoting himself with due diligence to the prosecution of original Research. If, in the opinion of the Committee, the Demonstrator engages in work incompatible with the due prosecution of Research, he may be removed by the Treasurer from his Demonstratorship.

5. In the records of such investigations as he may publish whilst holding the appointment he shall describe himself as the Griffiths Demonstrator of Pathology, and the work, if so done, as done in the Pathological Department of Guy's Hospital.

Guy's Hospital Golfing Society.

President: H. C. Cameron, M.D.

Vice-Presidents: H. L. Eason, C.B., C.M.G., M.S.; C. H. Fagge, M.S., F.R.C.S.; J. Fawcett, M.D.; H. W. Ormond, F.R.C.S.; F. J. Steward, M.S., F.R.C.S.; L. Bromley, M.Ch., F.R.C.S.; M. F. Hopson, L.D.S.E.; H. C. Malleson, M.R.C.S., L.R.C.P., L.D.S.E.

Captain: A. C. M. Coxon.

Committee: Messrs. B. M. Tonkin; K. F. McAlpine, —. Whelpton, B. L. Laver, W. G. Hore.

Hon. Sec. and Treasurer: J. W. Crook.

This Society was founded in 1908 for the purpose of promoting inter-hospital golf, and also to provide local interest by means of competitions, matches, etc. The Society is affiliated to the Clubs' Union, so all members of the Clubs' Union are members of the Society

A handicap tournament will be held each winter and summer session, and a monthly medal handicap competition is held on the first Wednesday in each month. Cards and information can be obtained from the Secretary.

Arrangements have been made by which members of the above Society may play on five days of the week, *i.e.*, from Monday to Friday, at Fox Grove Golf Club, Beckenham, on payment of an annual fee of £3 3s., without entrance fee. Also at Honor Oak and Forest Hill Golf Club, Honor Oak Park, for full membership on payment of £3 3s. per annum, without entrance fee; daily green fee, 2s. 6d. Also at Ilford Golf Club, Monday to Friday; annual fee, £1 1s., without entrance fee. Saturday, Sunday, and Bank Holidays at 2s. 6d. per diem. Also at West Essex Golf Club, Chingford, Monday to Friday, £2 2s. per annum; Saturday and Sunday, 2s. 6d. green fee.

Those wishing to pay the annual subscription at any of the above clubs should communicate with their respective secretaries.

Result of 18-hole Handicap Medal Round, played at Honor Oak and Forest Hill Golf Club on Wednesday, 13th August:—

	Score.	Hcap.	Nett.
*A. C. M. Coxon ...	78	4	74
K. F. McAlpine ...	96	14	82
A. A. Crowe	94	12	82
E. G. Browne ...	112	20	92

*Winner of handicap medal.

On Wednesday, 3rd Sept., a very enjoyable game, although weather conditions were rather warm, was played between Mr. O. Morgan's team and the Hospital, and resulted in a win for the Hospital by one match, one being all square.

O. G. Morgan beat A. C. M. Coxon, 2 up; B. M. Tweed lost to K. F. McAlpine, 8 & 7; A. N. Smith beat A. R. Crowe, 1 up; A. N. Donolon and W. B. Doherty, all square; Mrs. Tweed lost to R. E. Williams, 9 & 6; Bevan-Brown lost to F. W. Crook, 2 up.

Monthly 18-hole Handicap Medal Round, played at Honor Oak and Forest Hill Golf Club on Wednesday, 10th Sept., 1919.

	Gross Score.		Hcap.		Nett Score.
K. F. McAlpine ...	88	—	12	=	76
W. D. Doherty ...	94	—	16	=	78
A. C. M. Coxon ...	85	—	5	=	80
B. M. Tonkin ...	99	—	18	=	81
J. W. Crook ...	99	—	16	=	83
D. B. Whitlock ...	95	—	12	=	83
G. M. Stuart ...	89	—	3	=	86
L. G. Whelpton ...	103	—	12	=	91
T. Reed	113	—	20	=	93

It is very gratifying to notice the return of interest in golf by such a goodly attendance, and it is to be hoped next month will witness still more enthusiasts.

Don't forget the Biennial!

Birth.

OSBORN.—On August 21st, at Sheet Street, Windsor, the wife of Dr. A. G. Osborn, of a son.

Marriages.

DEBENHAM—ARCHER-SHEE.—On September 2nd. Leonard Snowden Debenham, B.Sc., M.B., B.S., to Anna, daughter of the late Martin Archer-Shee, of Bristol and Nailsworth, Gloucestershire.

ADAMS.—NUTTALL.—At Blackburn Parish Church, on Sept. 3rd, by Archdeacon Sale, Vicar of Rochdale, assisted by the Rev. C. H. E. Freeman, Vicar of St. Silas's, Blackburn, Frank Shirley Adams, M.B., B.Ch., of Clitheroe, Lancashire, younger son of Mr. and Mrs. Frank Adams, of Stoke-on-Trent, to Amy Kathleen, elder daughter of the late Mr. Alfred Nuttall and Mrs. Nuttall, Northwood, Blackburn.

SLESINGER—TRENCH.—On Sept. 2nd, at St. John's Church, Herne Bay, Kent, by the Rev. Thomas H. Groves, M.A., Edward G. Slesinger, F.R.C.S., to Gladys Eleanor, younger daughter of the late Arthur W. Trench, of Brooklyn, New York, and Mrs. Trench, of "Glendale," Forest Gate.

TWEED—ELVERY.—On July 18th, at Kill o' the grange Church, County Dublin, Martin Baird Moore Tweed, Captain N.Z.M.C., son of the late Dr. Tweed, of Ashburton, N.Z., to Marjorie Moss, youngest daughter of Mr. and Mrs. William Elvery, of Foxrock, Co. Dublin.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

THE sudden, and we might say almost unforgivable, action of the National Union of Railwaymen on Friday week, has roughly jolted the usually placid Londoner out of his groove. But with characteristic philosophy, he has speedily formed a new groove for himself, and is carrying on as best he can with his wonted cheerfulness. At Guy's, as elsewhere, the same spirit has shown itself, and we may congratulate ourselves that, considering the circumstances, we are doing remarkably well. The food question, of course, is foremost in everyone's mind, and on Monday last the hospital only received two-thirds of its usual milk supply, while a great shortage is felt in potatoes; otherwise, however, supplies so far have come in much as usual. Those who do not live in the College appear to be among the chief sufferers, and some have been forced to take a not unwelcome holiday.

THE Gordon Museum is undoubtedly one o our proudest possessions. On its shelves are some of the most priceless treasures in the possession of any medical community. Illustrations have been made from the specimens in such classics as Hilton's "Rest and Pain," while the anatomical models made by Joseph Towne are world famous. Many of the oldest specimens are still preserved in spirit, and some of the glass jars which contain them leak, so that their surface is continually wet with spirit. Obviously, under these circumstances, all who use the museum are expected to be scrupulously careful of fire, and it should be unnecessary for notices requesting men not to smoke in so sacred a place to be posted. Nevertheless, the notices are there in sight of all. It is therefore all the more surprising to see almost daily whole parties of men dropping into the museum with lighted pipes and cigarettes, striking matches for relights with the utmost "blazéness," apparently supremely indifferent to any danger to which they are exposing the specimens. Should a fire occur in the Gordon Museum, no amount of money or labour could ever replace these legacies to the medical profession and to humanity of which we are the proud custodians. We therefore make an urgent appeal to all to refrain from smoking in the museum, and we feel sure that Guy's men will not turn a deaf ear to this appeal.

YET another offence against the hospital has been brought to our notice. Perhaps next to the Gordon Museum we value most the Wills Library, and yet all may see that on two or three of the handsome oak tables therein some

individuals have been trying to perpetuate their names by carving them out of the oak. We should like to remind these aspirants to fame that there are other and perhaps more fitting methods of perpetuating one's name at Guy's; or if they consider these to be beyond them, Hampstead Heath gives far better opportunities for their present activities than the endowed portions of the Medical School.

The Rugby Football Season opens at Honor Oak Park on Saturday, October 4th, with a game against Catford Bridge. Practically all the pre-war fixtures have been revived, and judging by the form shown in the trial games, the season should be a thoroughly successful one. Thanks to the energy of a few enthusiasts, the game has been kept alive throughout the war, and in this respect the Hospital has been more fortunate than the majority of clubs. It must be admitted, however, that during the last few years the attitude of most men towards the game has been one of indifference; let us hope that a return to the old conditions will lead to a revival of that keenness which has always been one of the traditions of Guy's "Rugger." This season will see the revival of the cup-ties, and the whole-hearted support of the hospital cannot fail to increase our chances of success.

In addition to the 1st and "A" teams, the Nomads are being re-organised, and will play on Wednesdays. Finally, it should be pointed out that a fixture card entitles the holder to admission to the ground only, and not to the stand.

The attention of our readers is drawn to the notice about the Pupil's Physical Society, which appears in another column. This Society was revived last year when great keenness was shown, and the attendance at the meetings was excellent. Everyone in the wards should attend the clinical evening next Thursday, and every man in the hospital, from "fresher" to house officer, must be present when Sir William Hale White gives his address on "The Physical Society."

Dressers are asked to read carefully the lists of men on duty at the surgery, especially on Wednesday nights. These lists are scattered freely about the Hospital and College, and yet on Thursday mornings, when the new "take-in" week starts, it is frequent for nobody to turn up to run the "front." This causes additional labour for the already overworked "take-in" dressers, and as these lists are so widely distributed, ignorance of the fact that they are on duty is a hardly justifiable excuse for the absentees.

Ignorantia juris, quod quisque scire tenetur, neminem excusat.

It may be a fond conceit on our part, but we believe that many nurses read, and, perhaps, enjoy, the Gazette. Therefore we take this opportunity of reminding them that contributions, technical, humorous, or pathetic, about themselves at work or at play, will at all times be gladly received by the Editor. There are more nurses than men at Guy's, and we are convinced that much talent is lying latent in the Nurses' Home. Therefore in our future issues we hope to include much from the pen of the gentler sex.

It is fairly widely known by this time that the next volume of Guy's Reports will be devoted to photographs and biographical notes of Guy's men killed in the war. If anyone can obtain such photographs, which have not as yet been sent to the Gazette, it will be esteemed a great favour if they will send them to the Secretary of the War Memorial Committee.

T.B.L. ON THE WAR PATH!

As we are going to press, the clash of arms resounds through the College. On the night of October 1st a meeting was held in the College reading-room to discuss the preservation of law and order in the District. Amidst great applause our martial laryngologist explained the situation. Fifty residents in the College were asked to enrol themselves in squads of ten as special constables, each squad being under an elected sergeant. In addition, another hundred and fifty were to be called for from among the non-residents. Mr. L. Bromley, F.R.C.S., was unanimously elected sub-inspector. The ceremony of swearing in and the distribution of equipment was fixed to take place on the following morning.

Astley Cooper Studentship.

IT is probable that many of your readers have never heard of the Astley Cooper Prize which was founded by Sir Astley in 1839 when by his will he left to the Physicians and Surgeons of Guy's Hospital the sum of four thousand pounds to be held in trust for the establishment of a triennial prize of £300 for an essay on a subject in surgery, physiology, or anatomy, to be chosen by the Trustees. The essay was to "contain original experiments and observations which shall not have been previously published and it shall (as far as the subject shall admit of) be illustrated by preparations and by drawings, which preparations and drawings shall be added to the Museum of Guy's Hospital aforesaid."

The testator himself chose the subjects for the first six essays, and these would appear to be a curious selection for a surgeon who had made a European reputation rather as a clinician than as a scientific observer, as did Hunter before him, when we recount that five were pure histology and the sixth, on changes in the bloodvessels in inflammation, was microscopical pathology, but we should realise that at that time physiology was still regarded as part of surgery and that the histological aspect of anatomy had been recently given an enormously enhanced value by the production of achromatic objectives, designed by Selligue in 1830, and that Schleiden's paper of 1838, on which first a definite cell-theory was based, had just appeared. This is only a typical instance of scientific advance following the discovery of an instrument or method of increased precision.

The first Trustees were Bright, Addison, Babington, Aston Key, Morgan, and Bransby Cooper, who made the first award in 1844, when four essays were sent in, but the second subject only attracted one essay, though an award was made triennially until 1871, when the only competitor was disqualified. In that year the then Hon. Sec. to the Trustees (Dr. Wilks) tried to get the administration of the Trust amended in that "the object which the Testator had in view had almost failed, but they believed that this was not due to any remissness on their part" (as Trustees). The same question was mooted in 1895 and in 1907, for on many occasions no award could be made, four times because no Essay was submitted, and five times because the necessary conditions were not complied with. The Trustees have recently sought and obtained from the Charity Commissioners powers to modify the Trust on the grounds of the failure of the two chief objects of the Testator, viz., to stimulate original research and observation in Anatomy, Physiology and Surgery and to furnish the Museum of Guy's Hospital with constantly renewed preparations of pathological interest.

This failure is incontestible, but could it be urged that even one of the successful papers had added an observation of first importance to scientific knowledge, the Testator might have put posterity in his debt, though the objects he aimed at might not have been attained as he wished. This question cannot even be discussed within the limits of these notes, and would require far more expert knowledge than the writer possesses.

As will be seen from a notice which appears in another column, the Trustees are now empowered to devote the income derived from the Trust Fund to the foundation of a Studentship in connection with the Gordon Museum, hope that by doing so they will, in a most useful way as far as possible fulfil the desires of Sir Astley who, as is shown by the extract from his will quoted above, was very keen on maintaining a supply of material for the Museum. This had been founded about 1823,

and those who have in the years before the war had reason in revising the catalogue to delve in its archives will recall how frequently specimens which had been collected during the first years of its institution bore evidence of Sir Astley's interest, either from some personal note on a specimen from a case of his own or in a letter from an old Guy's man to his former master. Sir Astley's classical Treatise on Dislocations appeared in 1822, and most of the specimens from which this work is illustrated, and on which it is founded, still remain on our shelves, though, of course, they attract less general attention than those which illustrate his better known work on ligation of vessels.

Sir Astley in his will expressly excluded from the enjoyment of his legacy any member of the Staffs of the "Twin Hospitals," or anyone related by blood or by affinity to any Member of the Staff. It is strange that in 1839 he should have specially excluded St. Thomas's, for the separation had occurred in 1828, and, as was probable after the row of 1824, Sir Astley did not resume his lectureship at St. Thomas's when he returned to London in 1827 (Wilks and Bettany, History of Guy's Hospital). This clause in his will appears to be based on a desire to avoid nepotism at Guy's and resentment to St. Thomas's.

It will be seen from the advertisement that the regulations for the Astley Cooper Assistant contain a similar clause, and the Trustees wish intending applicants to understand that the exclusion applies only to Members of the Visiting Staff and to certain Lecturers and to any relatives of these officers.

C. H. FAGGE.

Pupils' Physical Society.

The Physical Society will start its new session by a clinical evening, to be held on Thursday, October 9th, in the College smoking-room. All men desirous of showing cases are asked to communicate with the Medical or Surgical Registrars and to let the Secretary know as early as possible, in order that a list may be posted in the Colonnade and other arrangements made.

During the first week of November a special meeting will be held in the Anatomical Theatre, when Sir William Hale White will deliver an address on the "Physical Society." This is in place of the more usual inaugural address which unfortunately cannot take place this year.

It is hoped to announce the date of this meeting in the next issue of the Gazette.

Leaves from a Medical Note Book

(1914—1918).

V. Post-Mortem Findings in Three Cases admitted as Cerebro-Spinal Meningitis.

The cases described hereunder were all admitted to a hospital in France during the 1915 epidemic of cerebro-spinal fever. In all three, death occurred within a few days of admission, and although the correct diagnosis was suggested during life in hospital, their admission as cases of cerebro-spinal meningitis from field units was well justified.

(1). Pte. H., age given 21, but looked 18 at most. Admitted comatose and died shortly after admission. Post-mortem examination showed congenital absence of left kidney and ureter. The right kidney was pale, contracted and granular, but, probably owing to previous compensatory hypertrophy, not very small in size. The left heart was enormously hypertrophied. There were some small gelatinous vegetations on the mitral cusps; the mitral orifice admitted three fingers. The aortic cusps were opaque. There was œdema and congestion of both lungs.

Cause of death.—Uræmia due to chronic interstitial nephritis in a single kidney.

(2). Pte. J., ? age, admitted with symptoms of meningitis. Died after some days.

Post-mortem examination showed in addition to great dilatation of surface veins of cerebrum, a thick, tough, adherent plaque about two inches square over the right occipital lobe, extending into the longitudinal fissure and causing adhesions of dura to cerebrum. Ventricles much dilated with clear fluid containing inspissated sediment, ? tuberculous choroid. Much basal lymph and opacity of pia. Pus in occipital sulci beneath plaque, and three small abscesses. At the apex of the right lung was a cavity of about the size of a golf-ball and containing sanguineous pus. Both apices puckered and adherent. Both lungs full of grey-white, infiltrated areas, not in relation to bronchioles. Compensatory emphysema. Two small patches of granular thickening below vocal cords. Stenosis of mitral valve admitting one finger. No tuberculous enteritis or peritonitis.

Cause of death.—Tuberculous meningitis secondary to chronic pulmonary tuberculosis.

(3). Pte. S., admitted with cerebral symptoms. Cerebro-spinal fluid contained pus and showed Gram-negative diplococci, but cultivations were sterile.

Post-mortem examination showed congestion of veins over vertex of brain. Base of brain covered with thick pus tracking down beside medulla. Cerebral abscess in left temporal lobe about equal to a walnut in size, with abscess-wall attached to bone over petrous portion of temporal. The abscess cavity communicated directly by a narrow channel with the left ventricle of the brain, which was filled with pus and débris and lined with a purulent membrane. The pus was malodorous. The third and fourth ventricles also contained pus, and the right lateral ventricle turbid fluid and flakes of pus. Left middle-ear contained pus, and the surrounding bone was blackened and softened, with a local spot of softening in the roof of the middle-ear in relation to the attachment of the abscess-wall described above. Lungs congested; other organs normal. Pus again showed Gram-negative diplococci. Two cases of cerebro-spinal meningitis had been reported in the unit from which patient came.

Cause of death.—Rupture of cerebral abscess into lateral ventricle, following chronic middle-ear disease.

The points of interest in these cases would seem to be, firstly, in regard to cases (1) and (2) that men with such definite and chronic disabilities as active pulmonary tuberculous and mitral stenosis in (1) and chronic interstitial nephritis in a single kidney in (2) should have reached the firing line and seen active service there. Secondly, in regard to case (1) that there was evidence suggesting the possibility of a previous meningitis in the plaque covering the occipital lobe. Thirdly, in regard to (2), that a man with a single kidney should have had the misfortune to develop at an early age a type of nephritis more commonly associated with advancing years. And fourthly, that a man hailing from a unit in which cases of cerebro-spinal meningitis had occurred, and showing Gram-negative diplococci in his cerebro-spinal fluid, should be found to have an obviously chronic and septic cerebral abscess to account for his symptoms and death.

The cases serve to recall the difficulties frequently encountered in differentiating cerebro-spinal fever from other diseases. In the observation ward at the same hospital, in addition to those described, cases of the following diseases were all seen, having been sent in as suspect cerebro-spinal meningitis—paratyphoid fever, trench fever (frequently), pneumonia epilepsy, and so-called influenza. At a later date the uræmic type of trench nephritis and spirochætosis ictero-hæmorrhagica in its early phases also occasioned problems in differentiation from cerebro-spinal meningitis.

(To be continued).

Guy's Hospital Dressers' Dinner.

January—June, 1919.

A very jovial dinner was given on Friday, Sept. 5th, at the Holborn Restaurant, by the full surgeons' dressers of January—June, 1919. The menu and etcs. left nothing to be desired, Mont blanc glacé plombière being in great demand.

After dinner an impromptu concert was specially arranged, and both those with and without vocal attainments responded lustily to the accompaniment of Mr. Remington.

Mr. Whitcombe gave choice selections from his repertoire of funny stories, and Mr. J. Victory's vocal score, "If you were the only girl in the world," aroused great enthusiasm.

Mr. Woodruffe brought down the house with "Pudden—Pudden—Pudden" and his slight-of-hand tricks were apt to baffle even the most observant sceptic.

Mr. William Gray arrived in the middle of the evening and melodiously sang "Lucky Jim," "Loch Lomond," and a peculiar chant about a Hansom cab driver, which unfortunately, during the encore, got mixed up with several other popular refrains.

This most pleasant evening, which was the means of bringing together again R.S.O.'s and H.S.'s. and dressers who worked together during those months, was brought to a close with the usual parting songs, which resounded along Holborn as the merry party dispersed.

REMEMBER!

Guy's Biennial Dinner, Oct. 28.

Amœbic Abscess of the Liver.

CLINICAL LECTURE BY Mr. DAVIES-COLLEY.

Gentlemen,—I have chosen amœbic abscess for the subject of my lecture to-day, because during the last few years I have seen a great many cases of it, and also because with the return home of the troops from the Mediterranean and farther East it is not unlikely that there will be cases developing here in England, and you may chance to come across some of them.

It is, perhaps, unnecessary for me to tell you that it is a disease associated with a high death-rate. The mortality is over 30 per cent., and in my own experience, which I may say at once was limited to the acute type of abscess, it was considerably higher than this.

Let me first say a few words about its ætiology and pathology. The part played by the amœba of dysentery in the causation of liver abscess is abundantly proved. In the first place, fully 80 per cent. of the patients give a history of dysentery in the past, though the history is not always easy to elicit in a country where diarrhœa from all sorts of causes is of common occurrence. And it must be remembered that it is by no means the rule for abscess to develop only in connection with the more severe types of dysentery—rather the reverse. Secondly, the amœba is found in the pus from the abscess cavity in most cases, not, as a rule, at the time of aspiration, but later, after the abscess has been draining for some days. And thirdly, inoculation experiments in in the hands of Wenyon and others have shown that injection of histolytica cysts into cats and dogs produce the characteristic signs of dysentery in the intestines, and liver abscess.

In all probability there is also some predisposing condition of the liver in most cases, such as congestion from exposure or alcoholic indulgence. It is difficult otherwise to explain the extreme rarity of liver abscess in women and children.

The course of the infection is clear enough. The amœba enters the portal system through the intestinal mucous membrane and is carried thence to the liver, where it produces hepatitis. If this does not resolve, it will go on to coagulative necrosis, and in fatal cases of dysentery, unsuspected of abscess, it is not uncommon to find post-mortem in the liver substance greyish areas of commencing necrosis. Later, liquefaction occurs and the abscess is formed. The abscess is single in about 60 per cent. of the cases, and to find more than three is very rare. In Mesopotamia the proportion of multiple abscesses was rather higher than usual, and this may partly account for the high death-rate in that country.

The abscess wall, in the acute stage, is shaggy and rough and very friable, breaking down easily with the finger, so that considerable hæmorrhage may occur during operation if the finger is roughly used in emptying the cavity. It is in the semi-necrotic tissue of the walls that the amœbæ are found, and it is only after the abscess has been drained for a few days that they begin to be discharged with the pus. If the abscess becomes chronic, a gradually increasing layer of fibrous tissue will form around it, as is shown in several specimens in our Museum.

The pus is usually described as being deeply stained with blood, and as the text-book description is never complete without the introduction of some article of diet, it is said to resemble anchovy sauce. As a matter of fact, in the cases I have seen it has as often as not been yellow and only slightly streaked with fresh blood, which has obviously escaped from the abscess wall during the evacuation of its contents. Floating in the fluid there are always masses of necrotic tissue, which, it is important to remember, are apt to block the lumen of your needle when you are exploring.

The commonest situation for an abscess is the upper and back part of the right lobe, and I do not remember to have seen in the left or other lobes except in cases of multiple abscess, in which the right lobe was affected as well.

Before discussing the symptoms and diagnosis I will read you the notes of a typical case :—

A private in the R.A.M.C., aged 25, was admitted into hospital at Amara in May, 1917. He had been in Mesopotamia for 14 months

and had latterly been employed at a marching post on the river Tigris. He gave a history of frequent attacks of diarrhœa during this last eight months. Occasionally he has noticed some blood in his stools, but this had never been a marked symptom; he had had treatment for it, but had never previously been in hospital. His present illness had started about a fortnight before admission with loss of appetite, a bad taste in the mouth, and a feeling of tiredness from morning to night. He had also lost flesh, about which he was very emphatic. From the first he had had discomfort, and a sense of fulness in the neighbourhood of the liver. In the last few days this had given place to definite pain, almost continuous, and sometimes acute, along the left costal margin. All around that neighbourhood the skin was tender on pressure. Every night during this time he had felt feverish, and latterly the fever had become more marked. Latterly, also, he had had very profuse sweating at night, though at that date the weather was fairly cool. He had been treated at the marching post with quinine, by a local medical officer, without any effect. His temperature on admission in the afternoon was 100°, and it rose to 102° in the evening. I saw him the next morning, and I was then impressed by his emaciation. His face was drawn and anxious, and his complexion muddy and slightly yellow, and there was a fairly deep flush over the malar bones. In the morning the temperature was 99°, the pulse 96, the respirations 26 per minute, and almost entirely thoracic in character, and deep inspiration caused pain. On inspection of the chest and abdomen there was seen to be obvious asymmetry between the two sides, the right lower ribs and upper part of the abdomen presenting a definite bulge. Palpation of this area was painful, and the right rectus was more rigid than the left. The liver dulness was an inch higher than normal in front; it rose somewhat in the axilla, falling again at the back; but there was no downward enlargement to be felt or percussed. The blood count, which had been made the previous night, showed 25,000 leucocytes, with 78 per cent. polymorphs. He was taken to the X-ray room and screened, and it was then seen that the right cupola of the diaphragm was considerably higher than the left, and it scarcely moved on respiration. A diagnosis of liver abscess was made, and he was taken at once to the Operating Theatre. An anæsthetic was given, and on exploration with a needle in the anterior axillary line pus was found at the first puncture. I removed a portion of the ninth rib, and drained the abscess cavity by means of a half-inch rubber tube. The cavity contained three quarters of a pint of slightly blood-stained pus.

He made an uneventful recovery. He had no pyrexia after the second day; the tube was shortened on the fifth day, and was removed on the fifteenth. He was evacuated to India on the twentieth day. Entamœba histolytica was recovered from the abscess cavity on the fifth day after the operation, and later from the stools. The pus on the day of the operation was sterile.

That is a typical case of moderate severity, and you will find, as we consider the symptoms in detail, that I shall not have many to add to those shown by this patient.

I have already laid stress upon the importance of a history of dysentery. The interval which elapses between the initial attack of dysentery and the onset of the liver infection is extremely variable, but it is scarcely ever less than three months. The only exception to this rule that I have seen was in a boy who had arrived with a draft from England and had only been a fortnight in Mesopotamia before he went sick with what was thought at first to be malaria. A week later he was found to have a large amœbic abscess of the liver, though he gave no history in the least suggestive of dysentery.

The insidious onset of the case I have described is characteristic, and so is the rapid wasting. I remember seeing one man who had a history of liver abscess for fifteen weeks. I do not know what his weight was, but I doubt if he could have scaled six stone.

Fever is present from the first. As a rule in the early days it is continuous and fairly high, 102° to 103°. As the pus develops, it tends to assume a remittent or intermittent type, rising at night to 102° or more and falling in the morning to 99° or less. Later, it becomes typically hectic, and there may be apyrexial intervals of a week or so. Rigors occur occasionally, but are not common, and profuse sweating, especially at night, is very characteristic. The degree of pain complained of by the patient varies enormously. There is

always a sense of weight or fulness in the liver region, and I have seen cases in which there has been nothing more definite than this, but, as a rule, there is pain, and sometimes it is very severe. The commonest situation for it is in the epigastrium and along the right costal margin; sometimes it is in the back below the scapula, or deep in the liver substance, or over the lower ribs, or it may be referred to the right shoulder. It is usually of a dull boring character, with occasional bouts of a sharp stabbing nature, and it is nearly always increased by deep inspiration or pressure over the liver.

The physical signs will not detain us long. You will generally notice a slight degree of jaundice, no more than a slight lemon tint of the skin, but enough to make you suspect the liver the moment you see the patient. The jaundice is never deep. And there is usually a well-marked hectic flush over the malar bones. On examining the chest and abdomen you will see that the breathing is mainly thoracic and that there is some bulging of the lower ribs and upper part of the abdomen on the right side. This asymmetry is very characteristic, and I cannot remember seeing a single case of liver abscess in which it was not obvious. The edge of the liver may be palpable below the costal margin, and if the abscess is low down in front you may obtain fluctuation over it; but it is surprising how frequently the liver may contain a large abscess without showing any downward enlargement at all. On the other hand upward enlargement can nearly always be demonstrated by percussion.

The blood-count is helpful, though it is by no means a reliable guide to pus in the liver, since a pre-suppurative hepatitis will often be accompanied by a high leucocytosis, while occasionally with an abscess the leucocyte count is as low as 10,000. As a rule, though it is between 20,000 and 30,000, and there is a considerable relative increase of the polymorphonuclear cells, a rising leucocytosis is, of course, particularly suggestive.

Of much greater importance is the X-ray examination, and apart from exploratory puncture, it is far the best diagnostic guide that we have. The pushing up of the right cupola of the diaphragm and its lack of mobility as compared with the left during respiration, are easily seen on the screen, and I came to the conclusion in Mesopotamia that in the presence of free movement of the diaphragm, exploratory puncture was useless.

Finally, there is exploratory puncture with a needle, about which I shall speak presently. The diagnosis in a straightforward case is not difficult when you are on the look-out for liver abscess, and a history of residence in a tropical country should be enough to put you on your guard; but many atypical cases are met with. An abscess low down in the back part of the liver is apt to simulate suppuration around a dysenteric ascending colon, and I have twice seen abscesses low down in the liver which had burst through the liver capsule and produced a perinephric collection of pus. One of these had discharged itself into the pelvis of the kidney, still further obscuring the diagnosis.

With abscesses in the upper part of the liver, basal pneumonia and pleurisy are most likely to be simulated, and it is not unusual to find one or other of these co-existing with a liver abscess; but though one frequently finds a slight excess of fluid in the pleura, I have only once seen a collection large enough to mask the liver dulness. A useful point to remember is that with pleuritic fluid the line of dulness is horizontal, whereas the upper limit of liver dulness is convex; also if you turn the patient on to his left side the liver dulness diminishes in the mid-axillary line much more than that due to a pleuritic effusion.

Suppuration in connection with a gastric or duodenal ulcer must also be remembered, but their previous history is generally so different from that of a liver abscess that there should not be much difficulty in excluding them.

Much the commonest problem to present itself is the question whether you are dealing with a case of pre-suppurative hepatitis or whether pus has formed, and if you have any suspicion that there is pus in the liver the correct proceedure is to explore with a needle. You need have no hesitation on the grounds of danger to the patient. Acupuncture of the liver does no harm, and there are good reasons to believe that it may clear up a hepatitis which would otherwise have gone on to suppuration, and I have seen several cases in which exploration was followed by the rapid resolution of symptoms which I thought could only be due to pus.

Exploration should only be done under an anæsthetic, and it is wise to have everything ready for immediate operation in the event of pus being found I have often had to make several punctures—sometimes as many as eight or nine—before striking the abscess, and this would have been impossible without an anæsthetic. With regard to the point at which to explore, unless there are definite localizing signs it is best to start in the anterior axillary line in the eighth or ninth space. The needle should be at least $3\frac{1}{2}$ inches long and should have a wide bore, because you are apt to encounter masses of coagulum and necrotic tissue in the abscess cavity which would block a small lumen.

If pus is found, two courses are open: (a) aspiration and the injection of a grain of Emetine Hydrobromide, and (b) open operation and drainage through the chest wall It is difficult to choose between these two methods, both of which have their adherents among the surgeons in India. I am biassed in favour of the open method, because I saw two cases in which the abscess had reformed after aspiration had been done elsewhere, and also because in cases in which I tried aspiration myself the open operation had subsequently to be done more often than not for the same reason. Whether the more chronic forms of abscess are more successfully treated by aspiration or not I cannot say, but I am inclined to think that they may be.

In view of these facts, my practice was to aspirate only those cases in which the patient's general condition was so bad that I thought they would not stand the strain of an open operation. These cases would often improve considerably after the bulk of their pus was withdrawn and one able to drain them safely a week or so later.

I will not detain you with a description of the operation, which differs but little from that of draining an empyema, but I will mention two points in connection with it. Firstly, the exploring needle which has tapped the abscess must be left in situ to act as a guide until the rib has been resected and the liver is exposed, otherwise there may be a difficulty in hitting off the pus again if the abscess is a small one; and secondly, the drainage tube must be a wide one and long enough to reach to the bottom of the abscess cavity, or the drainage will be insufficient.

The after-treatment of the wound is simply a question of changing dressings for the first few days. After the fifth day some surgeons advise syringing out the cavity with lamine or some other mildly antiseptic lotion, but I do not think this is necessary unless the discharge continues to be very profuse. Do not shorten the drainage tube until it begins to be pushed out by the contraction of the abscess walls.

It is best to start a course of emetine injections, two-thirds of a grain daily, on the second day after operation, and to continue them for ten days.

The post-operative complications which commonly occur are not numerous. For the commonest in my experience is the formation of a second abscess. Usually the temperature begins to fall immediately after the operation, and after the first day or two it remains normal. A sustained rise in the temperature during convalescence in the absence of pulmonary symptoms, means, in nine cases out of ten, more pus. This may be in the original cavity, re-collecting because the tube is too short; or there may be a new abscess developing. If lengthening the tube does not bring the temperature down it is best to give another anæsthetic and explore the cavity with a finger, and if no pocket of pus is discovered in this way the liver must be needled again, and any abscess that is found drained. I have had to open as many as four successive abscesses in one patient in this way. It is often possible to drain through the original wound, but one may have to make a new opening.

Bronchitis and broncho-pneumonia are fairly common, as in other acute abdominal conditions, and I had one case who, after having three liver abscesses successfully dealt with, finally succumbed to an apical empyema.

Fairly free hæmorrhage from the abscess walls during the first few hours after operation is not unusual, but I have never seen it severe enough to be dangerous. And finally a biliary fistula, due to the opening of one of the small bile ducts, is frequently seen during convalescence, but this is of no serious inport as it quickly heals with the contraction of the abscess walls.

Only three more weeks to the Biennial. Have you sent in your name?

Correspondence.

To the Editor of Guy's Hospital Gazette.

THE BIENNIAL DINNER.

Oct. 28th, 1919.

Dear Mr. Editor,—Thank you for inserting my previous letters about the Biennial Dinner. I now send you a first list of those who have signified their intention to be present. The list is not nearly so long as I should have liked, but in many respects it is fairly representative, and I hope that many of your readers, who are at present wavering, will find in it the name of some old friend whom they would like to meet, and will in consequence decide to come to the dinner, and will send me a post card to say so.

I am, Sir,
Yours sincerely,
F. J. STEWARD,
Hon. Sec.

98, Portland Place,
Oct. 2nd, 1919.

List of Guy's Men who have signified their intention to attend the Dinner.

1854—1869 (inclusive).

1854†	Dixon, J.	1868	Higgens, C.
1864	Savage, Sir G. H.	1869	*Durham, F.

1870—1879.

1870	Matcham, A.	1877	Mansell, E. R.
	Murphy, Sir Shirley	1878	Beale, E. Clifford
1875	Miles, Lt.-Col., M.E., C.B.E.		Lynn, E.
		1879	Howell, T. A. I.
	*Symonds, Sir C. J., K.B.E., C.B.		*White, Sir W. Hale, K.B.E.

1880—1889.

1880	Ashwell, H. G., Lt.-Col. R.A.M.C.	1885	Perry, Sir E. C.
		1886	Beard, F.
	Cameron Smith, J.		Burghard, F. F.
	Gosse, H. W.	1887	Brownfield, H. M.
1881	*Blatherwick, H.		Bryden, F. W. A.
	Milligan, R. A.		Cruikshank, J. W.
	Pitt, G. Newton		Randall, P. N.
1882	Hind, W.	1888	Roberts, J. L.
1883	Floyer, W. W.		Smith, G. Bellingham
1884	Counsell, H. E.	1889	Black, G.
	Humphreys, F. R., Major R.A.M.C.T.		Fripp, Sir A. D., K.C.V.O., C.B.
	Tubby, A. H.		Lansdown, R. P.
1885	*Farr, E. A.		Price Jones

1890—1899.

1890	*Fawcett, J.	1895	Partridge, A. H.
	*Richards, J. S.		*Shorland, E. T.
	Spurrell, C.		Steward, F. J.
	Stevens, T. G.		Stewart, H. M.
1891	Craig, M.	1896	Fagge, C. H.
	*Daldy, A. M.		Michael, C. E.
	Hopson, M. F.		Millbank-Smith, H. J. M.
	Jewell, J. W. F.		
1892	Fisher, W. H.		Ormond, A. W.
	Jackson, T. S.		Spon, H. J.
	Sheen, A. W.	1897	Cardin, H.
1893	Collier, H. W.		Cloud, F. H. L.
	Cooper, H.		*Fremantle, F. E.
	Edwards, F. H.		Wakefield, C, F.
	Eyre, J.		Way, M.
	*Jewell, W. H.	1898	Dowsett, E. B.
	Pearce, A. Chaning		*Eason, H. L.
	Wilson, F. W.		Henson, W. J.
1894	Allan, A. P.		Jones, J. H.
	Allport, A.		McGavin, L. H.
	*Hopkins, F. G.		Swan, R. H. J.
	Mawby, F. W.	1899	Kirkman, A. H. B.
	Robinson, W. E.		Miller, A.
1895	Ensor, C. A.		*Payne, J. L.
	Handley, W. S.		

1900—1909.

1900	Brydon, J. M.	1905	Eldridge, R.
	Camps, P. W. L.		French, R. E.
	French, H. S.		Palmer, F. W. Morto
	Goble, G. W.		
	*Nicholls, F. J.		Payne, O. V.
	Parrott, H. McD.	1906	Alcock, A.
	Shufflebotham, F.		*Davies-Colley, R., C.M.G., D.S.O.
	Steele-Perkins, J. S.		
	Taylor, T. G.		Goodhart, G. W.
1901	Atkins, Sir J., K.C., M.G.		Layton, T. B.
			Malleson, H. C.
	Bowen, W. H.		Ripman, C. H.
	Gray, A. C. H.		Stebbing, G. F.
	*Greenfield, D. G.		Vandermin, H. F.
	Hammond, J. A. B.		Zorab, A.
	Hardenberg, E. J. F.	1907	Aubrey, H. P.
	Tilbury, R.		Barnett, E. P.
1902	Pinching, C.		Carlill, H.
	Shipway, F. E.		Druitt, D. C.
1903	Bridger, J. D,		*Henderson, H. J. M.C.
	Goldie, E. G.		
	Robinson, G.		Jones, C.E.M.
	Spriggs, N. I.		Munden, W. P. H.
	Wallace, F. H.		Ryffel, J. H.
1904	Alcock, F.		Sheppard, A.
	*Cole, P. P.		Visick, H.
	Cowper, C. M. L,		Watson, J. N.
	Hughes, E. C.	1908	Chapple, H.
	Hurst, A. F.		Crook, A. H.
	Mollison, W. M		Johnson, W.
	Routley, E. W.		Palmer, A. S. Morton
	Ticehurst, G. A.		

1905	Cameron, H. C.	1909	Bromley, L.
	Clarke, H. M.		Collins, E. A.
	Crofts, A. D.		Lee, H.
	Dismorr, C. J. E.		

1910—1919.

1910	Barber, H. W.	1912	Zamora, A. M.
	Cox, A. Neville	1913	Bevan Brown, F.V.
	Dunderdale, G.		Creasy, R. (Junior)
	Hunt, G. H		Fry, W. K.
	Kidd, W. S.		Ogilvie, W. H., Capt. R.A.M.C.
	Munden, M. M.		Perceval, J. L.
	*Saner, F. D.		Roberts, C. S. L.
1911	Cook, F.		*Ryle, J. A.
	Glendining, V.		Scott, E. D.
	Hind, G. R.		Tanner, W. E.
	Mullally, G. T.	1914	Lambrinudi, C.
	*Marshall, G.		Muir Smith, L.
	Mutch, N.		Smith, C. R.
	Sandison, A.		Stallman, J. F. H.
	Todd, A. H.	1915	Coffin, S. W.
	Warner, H. P.		Curle, R.
1912	Eccles, J. D.		Price, H. Parry
	George, W. S.	1916	*Bates, K. L.
	Reynell, W. R.		*Heckels*, G. W.
	Soothill, V. F.	1918	*Debenham, L. S.
	Stewart, J. L.		*McKay, A. L.
	Stringer, L. B.		

† Date of Qualification.

* Vice-Chairmen.

Also Viscount Goschen, Mr. Cosmo Bonsor, Major Oswald Magniac, and the Editor of the Guy's Gazette.

Dear Sir,—The facts of every branch of knowledge have to be restated to each successive generation. This is emphatically the case with the Christian religion. The facts cannot change, but their presentation and interpretation must be in harmony with the highest current thought of the times. I know how hard it is for students of one branch to keep abreast of wider thought unless special effort is made. I am therefore arranging a course of lectures on religion and science by some of our religious leaders. Many people have been repelled by Christianity as it has been presented to them, but what has really repelled them is not Christianity but an obsolete statement. The first lecture will be given by Bishop Gore in one of the lecture rooms on October 16th, at 4 p.m. Lord Goschen has consented to take the chair. The next lecture will be given on Oct. 22nd, at 5 p.m. Dr. Temple will be the speaker. Further lectures, about two a month, will be announced later. I hope everybody will make a special note of the date.—Yours faithfully,

Guy's Hospital,
Sept. 30th, 1919.

A. E. POPHAM,
Chaplain (Temp.)

Extracts from the Letters of a London Medical Student.

(*Continued.*)

London, April 26th, 1817.

. . . . As you may suppose from the season, the lectures are drawing to a close. Those on Experimental Philosophy finished last Tuesday, but Dr. Curry's are so much behind that he lectures six times a week. The lectures at the College commence on the 5th May. I expect to get a members' ticket. Mr. Travers is now lecturing for Cooper on wounds. He has given eight lectures on Inflammation, and two on wounds of arteries; he will give a third on Monday night. I then go on to wounds of veins, absorbents, nerves, fascia, joints, muscles and tendons, and lastly on wounds of the face and neck, of the thorax, and of the abdomen. In tying arteries he is quite opposed to Cooper who, you know, applies two ligatures and divides the vessel between them. Mr. T. used a single ligature with a slip knot which he removes between the adhesive and ulcerative stage, and thus he is fighting Cooper in his own field. For my own part, had I to operate for aneurism I should apply one ligature and remove it in 12 hours. The operation is less dangerous and the wound heals in a fortnight less. Within the last three months Mr. Travers has had two excellent cases. I have, I believe, informed you that Cooper lost a patient on whom he operated for popliteal A. from wounding the femoral vein. A ligature was applied and death was the result. A patient also died last Wednesday from the vein being included in the ligature with the artery after amputation the preceding Friday. All the operations at St. Thomas's are performed by Mr. Travers, Chandler having refused the knife—pity, but old mother Forster would do the same. Mr. Travers is my favourite surgeon, and I pay my court particularly to him. He consequently takes much notice of me and has even taken me with him to see his private patients on whom he has operated; and he has invited me to his house, and indeed treats me with as much cordiality as if we were fellow students. We have our last meeting of the Physical Society next Saturday. A few of us are exerting ourselves to procure the return of Mr. Callaway, whom you probably recollect, an apprentice of Coopers, as one of the Presidents, and,

as time immemorial it has been the custom for men with minds to lead others by the nose, we flatter ourselves with success. I expect also we shall vote a piece of plate to Johnson the Secretary, who, by-the-bye, is an Examiner at Apothecaries' Hall. This, as well as the other, originated in your humble servant. I have got Callaway to propose and Bell (Lecturer on the teeth) to second it. I suppose I shall have to make a speech on the occasion. I hope to get my dissertation read pretty early next Session; subject Nervous Influence, not the easiest you will say. The prize subjects for next year are Poisons, and Diseases resembling Syphilis, on one or both of which I shall probably write. Any communications on the subject will be thankfully received. With regard to your Dissecting Society, I shall be happy to forward your views in any way in my power. I wish you may have better success than the last time. The acquittal of Donnall has excited unusual surprise here. To the satisfaction of Mr. C. I asked Dr. Babington if he had ever known Cholera Morbus produce Inflammation of the Stomach? He answered he had never seen, heard, or read of such a circumstance. I am glad to say he is not a Member of the College of Surgeons. I was at the College the other day and looked over the list for 1816. I had a skull and a section of a cranium given me a short time since, and a few days ago another cranium much damaged, but I expect to get from it a Sphenoid, an Ethmoid and the Palatine bones. I shall try my hand at making casts of the organ of hearing with the temporal bones according to Brookes' method.

A Case of Pyoneprosis occurring in a Polycystic Kidney.

Miss R. H., æt. 28, was admitted to Mary under Dr. Hurst, August 8th, 1919, from the South Eastern Hospital. Early in June she had a sudden abdominal pain which lasted for a few minutes and was followed during the next few days by several similar attacks which bore no relation to food. After the first attack she vomited several times. After being treated at home for some time, she was admitted to the South Eastern Hospital, where a diagnosis of enteric was made. There her temperature remained high for three weeks, so she was sent up to Guy's for further investigation. At no time did she have any constipation or diarrhœa. Three years ago she is said to have had a movable kidney (on which side she does not remember) for which she has worn an abdominal binder.

On admission she was very anæmic and wasted. Her temperature would swing from 99° in the morning to 101° or 102° at night. Her heart sounds were feeble, the so-called tic-tac rhythm being present; its rate varied from 100 to 120. There were signs of a little fluid at the left base of the lungs. At the left side of the abdomen a large, ill-defined lump could be felt. It was unlike a spleen, and did not seem to have the shape of a kidney. It projected down from under the costal margin, and was dull and slightly tender. Nothing was felt on the right side. The urine contained a small quantity of albumen and casts and a few pus cells, and a catheter specimen gave a growth of bacillus coli communis. The blood showed a slight leucocytosis.

A subphrenic abscess was diagnosed, and Mr. Rowlands operated (15th August, 1919), and evacuated much pus which gave a growth of *bacillus coli communis*. As no fall in temperature was found, and the patient got worse, a second operation was performed. No further collection of pus was found, but a retro-peritoneal tumour was felt which did not seem to have the form of a kidney. Two days later the patient died.

At the autopsy some general peritonitis was found. Both kidneys were large and cystic, weighing together more than 4,000 grams. The cysts were of all sizes up to two inches in diameter. On the right side these cysts were full of a brownish liquid, which was clear. Those in the left kidney were full of pus, and one cyst had ruptured and probably caused the peritonitis. There was no dilatation of the pelves of the kidney.

Two small perforated ulcers were found near the hepatic flexure of the colon, and there was an adhesion between the left kidney and the fourth part of the duodenum which had caused a great deal of dilatation of the duodenum.

A. McKENZIE.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Barbed Wire Disease. By A. L. Vischer, M.D. Basle, M.R.C.S. Eng., with introduction by S. A. Kinnier Wilson, M.D. Ed., F.R.C.P. Lond. (Published by John Bale, Sons & Danielsson.) 84 pp. Price 3s. 6d. net.

In this interesting little book Dr. Vischer discusses the origin of the symptom complex called in official documents "barbed wire disease," which was so common amongst prisoners of war. The symptoms are "irritability, difficulty in concentrating, restlessness, failure of memory, moodiness, depression, and unpleasant dreams." The frequency of this complex is proved by copious extracts from camp literature which tend to show that the cause is to be found in lack of privacy, sexual difficulties, absence of outside interests or fresh pursuits, and the uselessness of camp life.

A most interesting comparison is made with the symptoms of arctic explorers, monks, ships' crews and other groups where a multitude is closely confined for an indefinite period. Dr. Kinnier Wilson has written a most illuminating introduction in which the purely British aspect of the disease is dealt with, and Dr. Vischer's conclusions examined in their light. This book forms an interesting addition to our knowledge of war psychology, and should be read by all who are likely to have much to do with returned prisoners of war.

Aids to Histology (2nd Edition). By A. Goodall, M.D., F.R.C.P. (Bailliere, Tindall & Cox.) Fscap. 8vo., 135 pp. Price 3s.

A useful guide to the essential facts of histology, and will be found of great help to the junior student, and, for purposes of revision, to the advanced student. Some of the diagrams are poorly executed.

Catechism Series. Chemistry (Inorganic, Part I.) 2nd Edition. (Published by E. & S. Livingstone, 17, Teviot Place, Edinburgh.

A good book for revision, but lacks in style and completeness.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Specialities.

"Enolin" Tooth Paste.

A. & E. CARRERAS, LONDON, W. 6.

The need for a general and more insistent practice of dental hygiene has been greatly emphasised during the past few years by the attention which it has been considered necessary to give to the teeth of the men of the services. It is an essential factor beyond dispute that to maintain a perfectly healthy condition of the body as a whole, sound teeth and a healthy mouth are primarily necessary. It is an elementary factor in personal cleanliness which prevents disease and functional derangements and which by benefiting the individual raises the physical standard of the community. Not only are definite dental diseases such as pyorrhea attributed to neglect of the teeth, but the digestive tract is frequently affected. Oral sepsis is a most important point to be considered when polluted breath acts as a receptacle for all air-borne bacteria and may be regarded as suspect in connection with influenza, pneumonia, and most other respiratory affections. In this connection we have tested Enolin tooth paste as submitted by Messrs. A. & E. Carreras, and find it a preparation of excellent quality, manufactured from carefully chosen constituents. As an effective cleaning agent it leaves nothing to be desired, whilst its antiseptic properties are found to entirely conform to the requirements of the standard chemical tests. It is especially indicated in cases of pyorrhea, and where a stimulant is needed to render the gums healthy. Messrs. Carreras recommend the use of a wooden toothpick after meals and where possible a thorough brushing of the teeth with the use of Enolin Tooth Paste not less than twice a day. We have found Enolin to effectively destroy bacteria quickly with which it established contact, and it naturally follows that the more thoroughly the mouth and teeth are cleansed with Enolin the greater will be the proportion of micro-organisms destroyed. We can confidently recommend this pleasantly aromatic paste as a preparation of high quality and hygienic merit.

Ingram's "Eclipse" Hot Water Bottle.

The usual defect in the ordinary hot water bottle is its liability to leak after it has been in use a short time, and to discover a means of overcoming this trouble has always presented a difficult problem to manufacturers, the cause being that the water, working its way between the necessary brass socket and the rubber, travels towards the top. and hence the trouble in leakage.

Messrs. J. E. Ingram & Son, Ltd., are therefore to be congratulated on having, after much experimenting. devised a hot water bottle the neck of which has the

brass socket so embedded in rubber as to render any leakage impossible.

Although the price of these bottles is slightly above others on the market, they are far cheaper in the end, as they are the best and most reliable hot water bottles to be had.

Notices.

Norman Kerr Memorial Lecture.

The eighth Norman Kerr Memorial Lecture will be delivered in connection with the autumn conference of the Society for the Study of Inebriety, on Tuesday, Oct. 14th, 1919. The proceedings will be as follows:—

8.30, Breakfast.—At the invitation of the Chairman and Committee of the National Temperance League, at Polytechnic, 309, Regent Street, W. 1. An admission card will be sent to each member and associate making early application and as far as the limit of accommodation will allow. Those desiring to be present are invited to communicate with Mr. John Turner Rae, Secretary of the N.T.L., at the offices of the League, Paternoster House, 34, Paternoster Row, E.C. 4.

10.30, Morning Session.—In the hall of the Medical Society of London, 11, Chandos Street, Cavendish Square, W. 1. Presidential address by Sir Alfred Pearce Gould, K.C.V.O., C.B.E., M.S., F.R.C.S. Discussion opened by the Rt. Hon. Lord D'Abernon, G.C.M.G., on "The Scientific Basis of Drink Control."

2.0, Afternoon Session.—Discussion opened by the Rt. Hon. Sir Thomas P Whittaker, M.P., on "Alcohol in Relation to Recreation and Refreshment and the Public House." Papers will also be read and discussed at the morning and afternoon sessions as far as time will allow.

4.30, Tea.—In the library of the Medical Society of London.

5.30, Norman Kerr Memorial Lecture.

The conference and lecture will be open without fee to all members and associates of the Society, who may also introduce visitors on forwarding their names and addresses to the hon. secretary.

Post Graduate Course in Tuberculosis for Graduates in Medicine.

Three post graduate courses in tuberculosis will be given in Paris during the coming academic year under the direction of Messrs. Bernard, Bezançon, Calmette, Kuss, Letulle, Rist, Sergent and Teissier.

The courses will be of six weeks duration, commencing on October 20th, 1919, April 15th, 1920, and June 15th, 1920.

The courses will be essentially practical in nature and will include: pathology, bacteriology, physical diagnosis, X-ray, laryngology, social welfare and dispensary administration.

A feature of the course will be the opportunity to work each morning in a dispensary or hospital under the guidance of these physicians.

The course will be open to graduates in medicine who are citizens of France, allied and neutral countries.

The Commission for the Prevention of Tuberculosis in France will grant subventions to a limited number of French physicians.

Further details of the course may be secured by writing to Dr. E. Rist, 5, rue de Magdebourg, Paris.

Royal Society.

John Foulerton Studentships.

The Foulerton studentships are derived from a fund established by Miss Lucy Foulerton, in memory of the late Dr. John Foulerton, for original research in Medicine, the improvement of the treatment of disease, and the relief of human suffering.

The object of the studentships is to advance knowledge in these directions by enabling men or women of proved ability to devote themselves to research.

1. The awards will be made by the President and Council of the Royal Society acting with the advice of a Committee to be appointed by them for the purpose.

2. The studentships will at present be two in number and of the value of £400 each per annum.

3. The studentships will be tenable for three years in the first instance. They may, on the recommendation of the Committee, be extended, but the total tenure shall not exceed six years from the time of the first award.

4. Students will be required to carry out investigations under the supervision and control of the Royal Society.

5. Members of both sexes are equally eligible, but every candidate must show that he or she is and that his or her father and paternal grandfather are or were of British nationality.

6. Applications for the studentships shall be invited by public advertisement, and candidates shall be required to state whether they hold other endowments.

7. Every candidate for the studentship shall be required to state the general nature and scope of the research in which he proposes to engage, and the student shall keep the Committee informed from time to time of the progress of the research.

8. Any student desiring to undertake duties outside his research work must obtain the permission of the President and Council.

The Royal Society will proceed to elect to two Foulerton Studentships in the autumn of this year.

Candidates should state age, qualifications for research, and give references to not more than three persons, who can speak as to their previous work and experience in research.

Applications (marked outside "Foulerton Studentship") should reach the Royal Society not later than Oct. 31.

Royal Army Medical Corps.

TERMS AND CONDITIONS OF SERVICE UNDER TEMPORARY COMMISSIONS

(New Appointments and Re-appointment).

The period of contract is six months.

Pay will be at the following rates:

Lieutenants	£600 per ann.
Captains on rejoining or on promotion to that rank after one year's completed service	650 "

In addition to the above there will be issuable:—

(*a*) Pay at the rate of £50 per annum to all officers whilst serving elsewhere than in Europe.

(*b*) Rations or the allowance in lieu thereof.

(*c*) Specialist's or Charge Pay when the officer is holding a position for which the issue of such pay is authorised.

Officers holding acting rank or substantive rank higher than Captain will, if they so desire, be granted the pay and allowances of such rank in lieu of the above rates.

The contract will take effect from the date of joining for duty, and will not be terminable by either party thereto before the expiration of six months, except for misconduct, inefficiency, or medical unfitness.

The limit of age fixed for appointment is 45 years, except in the cases of candidates who have previously held commissions in the Royal Army Medical Corps during the present war, which will be specially considered if not within the above limit.

War Office,
Cornwall House,
Stamford Street, S.E. 1.

The annual service of the Guild of St. Luke will be held at St. Paul's Cathedral on Tuesday, October 21st, when evensong will be sung at 7 o'clock, and the preacher will be the Lord Bishop of London. Doors open at 6.30. Doctors and medical students are requested to wear academic dress.

Guy's Hospital Christian Union.

The Christian Union at Guy's was founded in 1847. From this time until outbreak of war the Union was very successful, but unfortunately, like most of the other hospital institutions, it has suffered through lack of members during the war. In fact, it was only through the untiring energies of a few men that it did not completely collapse.

Now that the hospital is regaining its pre-war status, and the various clubs are again springing into life, it is desirable that the Christian Union should once more receive the support of the students.

The Rev. T. W. Pym, D.S.O. (late Assistant Chaplain General to the Forces), will give the opening address on Monday, October 8th, and it hoped that every student will make a genuine effort to attend.

Lawn Tennis.

GUY'S v. REDHILL.

Played at Redhill on Sept. 6th, 1919. It resulted in a very good match, but ended in a defeat by 3 matches to 5 matches (one unplayed). Scores:—

B. L. Laver and W. H. Cellier lost to W. D. Waller and L. Bidlake, 3-6, 2-6; beat T. Thompson and J. E. Watson, 6-2, 1-6, 6-3; beat E. Bateman and A. C. Rickett, 6-2, 6-4.

J. W. Schollum and B. Keyter lost to W. D. Waller and A. Bidlake, 1-6, 0-6; beat T. Thompson and J. E. Watson, 1-6, 6-3, 8-6; lost to E. Bateman and A. C. Rickett, 4-6, 4-6.

P. Krige and K. M. Woodruff lost to W. D. Waller and L. Bidlake, 1-6, 7-9; draw with T. Thompson and J. E. Watson, 10-10; lost to E. Bateman and A. C. Rickett, 4-6, 4-6.

Hamlet in Utero; or the Aspiring Fœtus.

To flex or not to flex, that is the question!
Whether 'tis better as an R.O.P.
To let my head extend, and present myself a "Brow,"
Or even turn into a "Face," and make
The two convexities of spine, a good excuse
To give the nurse the chance she needs
To prove her diagnostic powers—
Or whether in this sea of amniotic fluid
To simply do a version on my own
And as a L.S.A. dilate the os,
And prolapse just an inch or so of cord!
But time grows short—
I feel the pains of labour round me press,
Increasing in their frequency and strength.
The membranes bulge—ah, me! my heart is sad—
I'm just an R.O.A.

Football Fixtures.

RUGBY.

First Fifteen.

1919.			
Oct. 4	Catford Bridge R.F.C.		Home
11	London Irish		Away
18	Old Alleynians		Away
22	Oxford University		Away
25	Rosslyn Park		Away
Nov. 1	Old Blues		Home
8	United Services		Away
15	London Irish		Home
19	Blackheath		Away
22	Harlequins		Away
26	Cambridge University		Away
29	Richmond		Home
Dec. 13	London Welsh		Home
20	Old Millhillians		Home
1920.			
Jan. 3	Rosslyn Park		Home
10	Old Merchant Taylors		Home
17	United Service		Home
24	London Scottish		Home
31	Catford Bridge		Away
Feb. 5	St. Mary's Hospital		Away
7	London Welsh		Away
14	Old Alleynians		Home
21	Coventry		Away
28	Old Leysians		Away
Mar. 13	Northampton		Away
20	Richmond		Away
27	Old Blues		Away

Second Fifteen.

1919.			
Oct. 4	Rosslyn Park		Away
11	R.M.A., Woolwich		Away
18	Old Alleynians		Home
25	Christ's Hospital		
Nov. 1	Old Blues		Away
15	Richmond		Home
Dec. 6	Edgware R.F.C.		Home
13	London Irish		Away
20	Old Millhillians		Away
1920.			
Jan. 10	Edgware R.F.C.		Away
17	Rosslyn Park		Away
Feb. 14	Old Alleynians		Away
21	London Irish		Away
Mar. 6	R.M.A., Woolwich		Away
20	Old Blues		Away

ASSOCIATION.

First Eleven.

1919.			
Oct. 4	Old Johnians		Home
11	Old Wilsonians		Home
18	London Hospital		Away
25	Old Westminsters		Home
Nov. 1	R.A.F. Uxbridge		Home
5	Brentwood School		Away
8	Old Aloysians		Away
15	H. A. C.		Home
22	St. Bart.'s Hospital		Home
29	Middlesex Hospital		Home
Dec. 6	St. Thomas' Hospital		Away
13	London Hospital		Home
20	Old Aloysians		Home
1920.			
Jan. 3.	Old Aldenhamians		Home
10	Bank of England		Home
17	King's College Hospital		Away
24	Ongar Town		Home
28	Brentwood School		Away
31	H. A. C		Away
Feb. 7	Old Bradfield Boys		Home
14	R. A. F. Uxbridge		Away
21	Old Citizens		Away
28	King's College Hospital		Home
Mar. 6	Old Wilsonians		Away
13	Bank of England		Away
20	St. Bart.'s Hospital		Away
27	Old Aloysians		Away
April 2	Old Owens		Away

Second Eleven.

1919.			
Oct. 11	Alleyn II.		Home
18	London Hospital II.		Home
Nov. 8	Alexander "A"		Home
15	H. A. C. II.		Away
22	Nestanglo		Away
29	King's College II.		Away
Dec. 6	Bank of England II.		Home
13	London Hospital II.		Away
20	Alleyn II.		Away
1920.			
Jan. 3	Old Aloysians		Away
17	H. A. C. II.		Home
24	Bank of England II.		Away
31	East London College		Home
Feb. 7	East London College		Away
14	Nestanglo		Home
21	Old Westminster II.		Home
May 13	Alexander "A"		Away

Ed.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

WITH incredible swiftness October has come round again, and with it a sea of new faces has flowed into the Hospital. Our readers for the past few issues have been looking for the usual Students' Number, and at last we submit to them this issue, the first Students' Number which we personally have launched.

During the past twelve months tremendous changes have been taking place in every community. Last October the war was not yet over, and now we have already settled down into such peaceful occupations as strikes and politics. Wherever we go, inside the Hospital as well as outside, we hear of reconstruction, we think reconstruction, and we talk reconstruction, and we may pride ourselves that at Guy's, at any rate, we *are* reconstructing—hard; but while we may congratulate ourselves that so far we have had some measure of success, in that we have amply proved that the old spirit and traditions of Guy's are by no means dead, it is apparent to all that there is much yet to be done, and we fully realise how much depends on this year's freshmen.

Not without some misgivings, therefore, do we take upon ourselves the responsibility of addressing the new-comers at this critical period of our hospital life; and we must apologise for any faults which are apparent in this issue, asking our readers to remember in their judgment that the Editorial mind is at present being tormented by the Conjoint Board of Examiners in England!

The changes which have recently been made in the educational curriculum at Guy's have necessitated a very thorough revision of that portion of this number which will be found under the title of "The Sciences." Indeed, we doubt if anyone could recognise this time-honoured article as it now appears in its new garb. It can be imagined how much work has had to be done to bring the whole matter up to date, and we take this opportunity of expressing our gratitude to those already overworked members of the Staff who have so willingly and so promptly helped in re-writing the paragraphs about their respective departments.

IF one could justifiably criticise the refreshing *joie de vivre* of the "fresher," it would be to remark that, as a rule, he makes either of two mistakes, namely, he works too hard, or he plays too hard. We would urge him to remember that—

"The string o'erstretched breaks and music flies;
The string o'erslack is dumb, and music dies."

If, therefore, we may presume to offer newcomers any suggestion, it is to work hard while they are at work, and to play hard while they are at play, and not to let either occupation encroach upon the time of the other. At Guy's they will have ample opportunity for doing both. Concerning their work, we refer them to the columns of the present issue of the Gazette. As regards games, of course few can hope to get into the first teams of clubs of so high a standard as the Guy's Clubs' Union, but we should like to remind them that second and even third teams are run, so that it is quite unnecessary to go outside the Clubs' Union for their necessary recreation. Lastly, may we remind them that they have just entered one of the firmest brotherhoods in the world, and we urge them to remember that any action of theirs, however noble or however despicable, reflects upon the honour and good name of Guy's.

We trust that all new medical, as well as dental, students will read, mark, learn, and inwardly digest that remarkably fine, and we might almost say beautiful address to new dental students, delivered by Mr. Hopson, which appears in another column of this issue.

We would draw the attention of our readers to "The Old Vic," in Waterloo Road. This unique theatre, being partly endowed, is able to give Shakespeare and opera at a low price, yet beautifully staged and acted. The plays are produced and acted by that really fine Shakespearean actor Russell Thorndike and the "Vic." company, and the operas are on the same high level of excellence.

Lovers of Greek plays should see Euripides' "The Trojan Women" (Murray's translation) at a matinée performance on the next three Tuesdays, with Miss Sybil Thorndike as Hecuba.

As we go to press Bishop Gore gives the first of the course of lectures on Religion and Science. The next lectures are—
October 22nd, at 5 p.m., Dr. Temple.
November 4th, at 4 p.m., Rev. Neville Talbot.
November 27th, at 4 p.m., Dr. Frere.

Most of us rather enjoyed our brief period of active service with the police force during the recent disturbance, and it seems that everyone came away with a very high opinion of the individual constable of the Metropolitan Police, an opinion which always has been held at this Hospital. On another page we publish a short account of our activities. It will be seen that for the present the organisation is to be retained. It is fully realised, of course, that the special constables are in no way "strike-breakers," and that their sole function is the protection of their fellow-citizens. Fortunately during the recent strike no violence was shown by either side, and the "specials" had little to do in the way of keeping order. It must be remembered that the special constabulary takes neither side in any dispute. Thus any citizen, whether he belongs to capital or to labour or to neither, can fulfil his duty to his fellow-citizens by joining the present force.

We should like to take this opportunity of expressing to Chief Inspector Layton, Sub-Inspector Bromley, Sub-Inspector Winston, and all the other officers, our appreciation of the keenness and efficiency that they have shown during the critical week-end.

We have much pleasure in congratulating Nurse Strain, Head Nurse Charity Ward, on having been awarded the Gold Medal for 1919, she having obtained the highest number of marks in the Nursing Examinations. Her medal was presented to her by the Right Hon. Viscount Goschen.

Papers by Guy's Men.

W. H. Bowen, M.B., M.S., F.R.C.S.: Some practical considerations on the operation for removal of adenoids and enucleation of tonsils.—*B.M.J.*, Oct. 4th, 1919.

Preliminary Address to New Dental Students.

By M. F. HOPSON.

Gentlemen,

My first duty, indeed my privilege, is to address a few words to the new men who are present. Speaking on behalf of my colleagues and the present students, I bid you a very hearty welcome. We are delighted to see you here in such large numbers, especially those of you who have come from over seas, and I can promise you all a very good time if you are prepared to play the game.

You have chosen of your own free will to seek and obtain the prerogative of calling yourselves Guy's men. What that signifies and stands for, all that it means, you will not fully realise until you have lived in the atmosphere of the old place for some considerable time, but if you are made of the right stuff it will soak into you gradually until finally you become saturated with it.

But I want you to seize hold of this right at the start, that you are first, and for all time, Guy's men, and the fact that you have entered as Dental Students is quite a secondary matter. Further, when a few days ago you signed the roll in the Medical School Office, you in a measure ceased to be absolutely free agents, for you incurred the responsibility of taking your share in maintaining the reputation and traditions of this great institution, and we are as jealous of the one as we are proud of the other. If you are not prepared to help us in this, you have made a great mistake in coming here, and I tell you frankly we have no earthly use for you.

In your clinical work do not forget that the treatment of the patient is just as important as the treatment of disease. You are no longer working on a "phantom," but dealing with a sentient, often hyper-sentient, human, who has just as much claim upon your skill and consideration as a private patient. Moreover, you are acting on behalf of a public institution and therefore open to public criticism; hence it behoves you to be punctilious in the discharge of any duties entrusted to you.

In all operative procedures, Be thorough, Be gentle, Be quick, may be taken as a sound working rule, and you may regard the relative importance of these qualities as being in the order stated. A thing which is well and properly done is done quickly enough.

Next, as to you school work. You have an immense amount of work to get through in a comparatively short period, far too short in my opinion, hence, method is everything, and "patience and tenacity of purpose are worth more than twice their weight of cleverness." Do not take everything you are told, or all you read, for granted; so far as you are able, put it to the test, and prove it for yourselves. Keep your eyes open and observe. Do not jump at conclusions; connote your observations, then think them over, and you may arrive at some new and interesting fact. Do not rely upon being spoon-fed by your teachers. Their business is to help you to learn. The motto of this Hospital is "Dare quam accipere"—It is more blessed to give than to receive—and on the flyleaf of every text-book you possess you might with advantage write this paraphrase: It is more blessed to learn than to be taught.

There is another thing I would warn you against, and that is working solely with your eyes glued on an examination. Huxley once said that "Examination, like fire, is a good servant, but a bad master." Do not let it become your master. Do not work merely to pass; work to know. There are unfortunately many who pass and who do not know.

Whilst you are here you will have the opportunities of laying down a foundation on which to build knowledge, such as may never occur again. Seize them and remember that true culture is but the sediment of things we have forgotten.

You have to be learners all your life, and the best student is he who, when he has passed his qualifying examination, is most conscious of the fact that he must be a learner still.

Honours.

Bar to Military Cross.

Lieut. (Act. Major) James La Fayette Lauder, D.S.O., M.C., 138th Field Ambulance. For conspicuous gallantry and marked devotion to duty during the operations October 14th–20th, 1918, as officer in charge of forward bearer officers of brigades. He worked continuously, personally directing the evacuation of wounded from the regimental aid-posts east of Courtrai wherever the casualties were heaviest, encouraging the bearers, and setting a splendid example under heavy fire to those under him.

Hysteria in War and Peace.

CLINICAL LECTURE BY Dr. A. F. HURST.

Gentlemen,—The war afforded an opportunity such as had never occurred before for investigating hysteria in men. The lessons we have learnt can be applied to the elucidation of many of the problems presented by the hysteria of civil life. In this lecture I shall attempt to explain the new conception of hysteria which I have been led to adopt as a result of my experience of the war neuroses.

I shall begin with a new definition of hysteria:—Hysteria is a condition, in which symptoms are present, which have been produced by suggestion and are curable by psychotherapy.

This definition differs from all others in not recognising an hysterical condition apart from the presence of definite hysterical symptoms. Charcot believed that hysteria manifested itself in two ways: by the symptoms that were obvious to the patient and about which he complained, and by physical and mental symptoms, stigmata which were present before the obvious symptoms appeared and which persisted after their removal.

Physical Stigmata of Hysteria.

A characteristic feature of the physical stigmata he described, the chief of which were *certain forms of anæsthesia and narrow fields of vision*, was that the patient never complained about them and did not, indeed, become aware of their existence until they had been demonstrated to him by the physician. Babinski showed that this was due to the fact that they *did not exist until the physician found them*, as they were actually produced by him unconsciously in the course of his examination. In a series of 100 consecutive cases of hysteria, which he examined in such a way that no suggestion could occur, neither anæsthesia nor a *narrow field of vision* was ever found.

Our investigations, carried on during the past 12 years, entirely confirm Babinski, and we have recently extended our observations still further. A spiral field of vision has often been regarded as even more characteristic of hysteria than the simple narrowed field described by Charcot, which Babinski proved was only the result of the suggestion involved in using a perimeter. When, after the first examination of the field was completed, and second and third examinations were made without interruption, the field was found to become steadily smaller, this being due, it was supposed, to the abnormal fatiguability in such cases. Major J. L. M. Symns and I found, however, that it was simply due to the method commonly used, in which the white disc of the perimeter is brought from without inward at each examination. When it was moved in the opposite direction, an outward spiral instead of an inward spiral field was obtained, the field becoming steadily larger until it reached the normal instead of becoming steadily smaller. By varying the method used, it was possible to obtain an inward spiral with one eye and an outward spiral with the other, or an inward spiral with one eye followed by an outward spiral with the same eye.

Accurate measurements made with J. L. M. Symns proved also that the supposed pharyngeal anæsthesia of hysteria is a fallacy, and that the *percentage frequency of deficient*, average and increased sensibility is exactly the same in patients suffering from hysteria, and even from such hysterical symptoms as aphonia and mutism, as in normal persons.

The areas of cutaneous anæsthesia that have been regarded as characteristic of hysteria were shown to be simply those areas that an average layman would expect to be anæsthetic if he were paralysed, and which would, therefore, be likely to develop directly he is questioned on the subject and his cutaneous sensibility is investigated.

Mental Stigmata of Hysteria.

Having disposed of the physical stigmata of hysteria, it becomes necessary to examine the mental stigmata. A study of the literature reveals a great diversity of opinion as to their nature. The stigma which is accepted by the largest number of writers and which is the only one accepted by Babinski, is abnormal suggestibility. But our investigations have proved conclusively that although abnormal suggestibility renders a man unusually prone to develop hysterical symptoms, there is no one who is so devoid of suggestibility that he may not develop them if the suggestive influence is sufficiently powerful. Whether a given person will develop hysterical symptoms under given conditions depends on the degree of his suggestibility and the strength of the suggestion. It is clear, therefore, that abnormal suggesti-

bility is simply a predisposing factor and is no more a part of hysteria than a tuberculous family history is a part of phthisis. Many cases of gross hysterical symptoms occurred in soldiers, who had no family or personal history of neuroses, and who were perfectly fit until the moment that one of the exceptionally powerful exciting causes, such as occur comparatively rarely apart from war, suggested some hysterical symptom; and after its disappearance as a result of psychotherapy the man was once more perfectly fit, and his subsequent history showed that he remained no more liable than any of his companions to develop new symptoms.

The following experiments made with J. L. M. Symns and R. Gainsborough show how unexpectedly suggestible the average normal individual is. We examined twenty-eight men who were perfectly healthy and suffering from no kind of nervous disorder, but who were attending an aural out-patient department for deafness, which was either unilateral or more severe in one ear than the other. Both ears were lightly touched, sometimes by ourselves, sometimes by others who did not know what we were investigating, and the men were then asked which side they felt more clearly. Eighteen replied at once that the ear in which the hearing was less impaired was more sensitive to touch than the other; the hysterical anæsthesia which had been suggested by this simple examination was so marked in one case that the man was seen a few minutes afterward putting a pin through the lobe of his ear to amuse his companions. In 1859 Briquet stated that hysterical deafness is associated with anæsthesia of the external ear, and this has ever since been regarded as an almost constant phenomenon, which was supposed to help in the differentiation of hysterical from organic deafness. The experiment just described throws light on the origin of this deeply-rooted fallacy.

As soon as it is recognised that although certain mental stigmata predispose to the development of hysteria, they are not themselves a part of hysteria, it becomes obvious that many cases of hysteria will be missed if it is only looked for in so-called hysterical persons. When, on the other hand, it is remembered that there is nobody who may not develop hysteria if the provocation is sufficiently great, it must follow that hysteria is infinitely more widespread than has generally been supposed.

Hysterical Symptoms following Emotions. — In the majority of cases very little difficulty is experienced in discovering the nature of the suggestion which gives rise to hysterical symptoms. The chief varieties seen in soldiers may be taken as examples, though each has a much wider application to the hysteria of civil life. In the first place, there are the symptoms which follow the emotion of fear. Extreme terror gives rise to certain familiar symptoms, the individual becoming shaky, "paralysed with fear," and unable to speak—"his tongue cleaves to the roof of his mouth." Under ordinary conditions the cause of fear is momentary and the physical results disappear in a few seconds. But during a heavy bombardment a man often remained terrified for hours. If the tremor, inability to move the legs, and speechlessness persisted all this time it was natural that these physical expressions of fear, which were not in any way hysterical, should make such an impression on the individual's mind that when the original emotion had disappeared, the tremor, paraplegia, and mutism, should persist as hysterical symptoms.

In the first two years of the war, cases of this kind were given the unfortunate name of "shell-shock" in the belief that they were organic in origin and due to the actual concussion caused by the explosion of powerful shells. Consequently no attempt was made to cure them by psychotherapy, and the treatment by rest and sympathy helped to perpetuate them; this unfortunate result was increased by the use of the word "shell-shock," which gave the patient the idea that he was suffering from some new and terrible disease. When at last the true nature of the condition was recognised, it was found that psychotherapy not only resulted in the immediate disappearance of the symptoms, when they were treated in the special Casualty Clearing Stations opened for the purpose by the British and French, such as that controlled by Major W. Johnson, but cases of two and three years' standing were also frequently cured at a single sitting in hospitals in England. Although this form of hysteria was most common in neurotic individuals, a large proportion of the patients treated within the first forty-eight hours recovered so completely that they were able to return to the firing line and showed no tendency to relapse. A few of the patients whose condition had persisted for many months before coming under treatment could not return to France, but such men were always able to go back to their old civil occupation and often had no underlying mental condition requiring

further treatment, although in some cases the hysteria was associated with neurasthenia or psychasthenia or both. Indeed many patients at once lost such symptoms as headache, depression, insomnia and nightmares, which had troubled them for months or even years, directly the obvious physical symptoms, such as mutism or stammering, tremor and paraplegia, were removed by explanation, persuasion and re-education.

Hysterical Symptoms following Gassing.—The second great group of hysterical symptoms in soldiers resulted from gassing. The irritation of the eyes, throat and stomach caused conjunctivitis, lanyngitis and gastritis, the latter being due to the swallowing of saliva in which the gas was dissolved. The pain caused by the conjunctivitis induced the patient to refrain from opening his eyes with his levator palpebræ superioris; if, however, he tried to open them, his attempt was frustrated by a reflex protective spasm of his orbicularis palpebrarum. Under ordinary conditions the conjunctivitis had improved sufficiently at the end of three weeks for the eyes to be opened without difficulty, but if the patient was led to fear for his vision on account of previous weakness of the eyes, the previous loss of one eye, as in two of our cases, or too prolonged treatment with local applications, bandages, dark spectacles or eye-shades, the voluntary inhibition of the levator might be perpetuated as hysterical ptosis and the reflex spasm of the orbicularis as hysterical blepharo-spasm. As the uneducated layman associated the idea of blindness with inability to open the eyes, many of these patients thought they were blind. Consequently when they were taught to open their eyes it was found that they could only see indistinctly, as they had hysterical paralysis of accommodation, or less frequently they could not see at all, as they had become so convinced that they were blind that they had ceased to look, and, not looking, they could not see. Simple explanation followed by re-education in looking resulted in permanent recovery. Similar cases, generally of much less severity and often consisting of nothing more than frequent blinking, are not uncommon in civil life.

In the same way the whispering in cases of laryngitis, which was originally in part voluntary in order to avoid pain and in part due to a protective reflex, was frequently perpetuated as hysterical aphonia. This was most commonly the case when an expert laryngoscopic examination had revealed the presence of some abnormal congestion which led to intralaryngeal medication, as both the diagnosis and treatment afforded the necessary suggestion to perpetuate the idea in the patient's mind that his voice was permanently lost. When these patients were taken away from their unfavourable surroundings and treated by explanation, persuasion and re-education without any recourse to suggestion by electricity, anæsthetics or other means, they invariably recovered. Each one of a series of 100 patients treated at the Seale Hayne Hospital was cured at a single sitting, although the average duration of the aphonia before admission was 205 days. About one-third of these cases were not caused by gassing, but by the same suggestive influences as those that give rise to hysterical aphonia in civil life. We believe that the liability to relapse is greatly reduced by our simple method of treatment and the avoidance of suggestion.

The gastritis caused by gassing resulted in vomiting—a protective reflex which fulfilled its object by removing the irritant from the stomach. The actual gastritis rapidly disappeared, and whenever the vomiting persisted for more than three or four weeks it was always hysterical. A very large number of soldiers were invalided from the service for so-called gastritis, the only symptom of which was vomiting. We found that cases of this sort could be cured by a single conversation, if this was continued until the patient was obviously quite convinced that he was no longer suffering from gastritis and that he could eat anything without fear of vomiting, even if he had vomited after every meal for many months and had been kept on a strictly fluid diet. Many examples of this are recorded in an article by Captain W. R. Reynell in the Seale Hayne Studies.

Hysterical vomiting is much more common in civil life than is generally supposed. I believe that all cases of the so-called pernicious vomiting of pregnancy are really due to the hysterical perpetuation of the vomiting, which is physiological during the first few weeks. Similarly the persistent vomiting, which is a common symptom in young anæmic women and was formerly regarded as evidence of gastric ulcer, is generally hysterical and is due, like the vomiting in soldiers after gassing, to the perpetuation of a symptom produced originally by an acute attack of gastritis. The vomiting in chronic appendicitis, which may continue even after the removal of the diseased appendix, and

of phthisis, and the cyclic vomiting in children, are in great part hysterical. All these varieties of hysterical vomiting can be cured by simple explanation, generally at one sitting, just as in soldiers, and require none of the treatment by isolation, dieting and drugs, which is commonly given, even by those who suspect that there is a nervous element in the condition.

Hysterical Symptoms produced by Trivial Wounds of Limbs.—Perhaps the most common of the hysterical conditions in soldiers were the paralyses and contractures which followed comparatively trivial wounds of the limbs. A great many different forms were observed, and in many cases the paralysis and contracture were associated with marked vasomotor disturbances, including cyanosis or pallor, a pulse of small amplitude, œdema and trophic changes in the skin, nails and bones. At the same time the muscles showed a moderate degree of atrophy, accompanied by an increased irritability to mechanical stimulation and certain changes in electrical reactions, which did not, however, amount to the reaction of degeneration. These changes were often most easily observed under a general anæsthetic, which did not result in complete relaxation of the spasm until a stage of anæsthesia was reached beyond that in which consciousness is first lost. Babinski and Froment experienced considerable difficulty in producing any improvement in the paralysis and contracture by psychotherapy. Impressed by this and by the fact that the associated vasomotor and trophic conditions could not possibly be hysterical, as they were obviously neither capable of being produced by suggestion nor cured by psychotherapy, they concluded that the paralysis and contracture were also not hysterical. They revived the old theory of reflex nervous disorders, with which Vulpian and Charcot had sought to explain the muscular atrophy and spasm that often accompany diseases of joints. They ascribed both the muscular symptoms and the associated vasomotor and trophic disturbances to some obscure form of reflex action.

Our experience has led us to believe that there is no foundation for this theory of Babinski and Froment, and that all the cases they describe as reflex are really hysterical. The immobility and spasm may arise as a voluntary or reflex response to pain, or they may be due to localised tetanus, or to the application of splints or bandages; the abnormal posture and the immobility and spasm are perpetuated by autosuggestion after the primary cause has disappeared, and to this is very often added the heterosuggestion involved in treatment by electricity and massage. The hysterical paralysis and contracture which result could invariably have been prevented by persuasion and re-education directly the condition of the wound made active movement permissible.

The hysterical nature of the paralysis and contracture is proved by their rapid cure with psychotherapy. In a series of 100 consecutive cases treated at the Seale Hayne Hospital, the majority, if not all, of which might have been diagnosed as reflex, as each one of the cases shown in the illustrations of Babinski and Froment's book was represented in our series, ninety-six were cured at a single sitting of an average duration of fifty-four minutes, and the remainder were cured in four days (two cases), two weeks and four weeks respectively, although the average duration of treatment before admission was eleven months. It is clear, therefore, that the paralysis and contracture are hysterical, as they are caused by suggestion and cured by psychotherapy.

Disuse of a limb, whether caused by organic disease or hysteria, leads to deficient circulation. This by itself is enough to explain the associated vasomotor symptoms, as they are most marked in cold weather and in individuals who have always had a feeble peripheral circulation. They disappear temporarily, as Babinski and Froment showed, by artificially increasing the circulation by the application of heat, and permanently, as we have repeatedly observed, by restoring the power of movement by means of psychotherapy.

Deficient circulation gives rise in turn to deficient nutrition, so that the skin and subcutaneous tissues become atrophied, the bones decalcified as shown by the X-rays, and the nails thin and brittle. In a striking case, in which some trophic changes had developed as a result of hysterical paralysis and contracture of over a year's duration, and in which the power of movement was restored at a single sitting, the nails subsequently showed a very definite horizontal line separating the opaque, vertically ridged, thin and brittle part which grew during the period of disuse, from the pink, smooth and otherwise normal part, which began to grow immediately recovery took place.

The changes in mechanical and electrical reactions and in the deep reflexes were also shown

by Babinski and Froment to disappear when the circulation was temporarily improved by immersion in hot water, and we found that immediate and permanent restoration followed recovery from the paralysis and spasm as a result of psychotherapy. These changes, therefore, are nothing more than the functional effects on muscular tissue of deficient circulation.

In the same way the rigidity of the finger joints observed both in cases of organic nerve injury and hysterical paralysis and contracture, which persists under deep anæsthesia, has always been regarded as due to adhesions or fibrous contractures, which only gives way under forcible manipulation with sounds of tearing and resulting effusion. This condition is really the result of some coagulative process in the fibrous tissue caused by the accumulation of products of metabolism, which are normally removed by the blood when the circulation is efficient. It is well known that a slight increase of mobility of such joints follows the application of warmth, which improves the circulation, and we have found that complete and immediate restoration of mobility followed the return of the natural circulation as a result of the rapid cure of the paralysis and contracture. This must have been due to the removal of waste products permitting the temporarily coagulated fibrous tissue to assume its normal fluid consistence.

It is thus clear that the so-called reflex nervous disorders of Babinski and Froment are really hysterical, and that the associated vasomotor and trophic disorders are caused by the resulting disuse.

Hysterical Symptoms following Injury or Disease of the Nervous System.—The last group of cases is, I think, the most important, because it is one which is very common both in soldiers and civilians, though its true nature is comparatively rarely recognised. It consists of symptoms which are primarily organic and due to an injury or disease of the nervous system, but which are eventually in part or completely hysterical. When the structural changes produced by an injury or acute disease of the nervous system gradually diminish in extent owing to the disappearance of the vascular and other temporary changes which surround the comparatively small area of total destruction, if indeed such an area is present at all, the symptoms caused by the throwing out of action of the parts controlled by the nervous tissues primarily involved should disappear pari passu. Just as the physical signs in slowly progressive diseases, such as tabes and disseminated sclerosis often precede the onset of symptoms, so in these cases the physical signs are generally still present when the functional capacity has returned to normal, and if the lesion does not disappear completely they may remain as permanent evidence of a past organic lesion.

In many cases, however, a man does not realise that his functional capacity is improving. If he has been hemiplegic, he has in the early days made repeated efforts to move his paralysed limbs, but without success, and he finally gives up the attempt and reconciles himself to the idea of permanent hemiplegia. If his physician is too much concerned with the possible dangers of early movement, he will exaggerate the patient's own fears of permanent disability, with the result that the organic hemiplegia is gradually replaced by hysterical hemiplegia instead of slowly disappearing as the organic lesion becomes more and more reduced in extent. A time may eventually arrive when the hemiplegia is entirely hysterical, but, as already pointed out, the physical signs of organic disease, such as extensor plantar reflex, ankle-clonus, exaggerated deep reflexes and lost abdominal reflex, may still be present on the affected side.

A number of additional signs have been described, particularly by Babinski, which depend on the fact that the behaviour of the paralysed muscles in organic hemiplegia differs in various respects from what an average layman would expect, so that a man with hysterical hemiplegia, the exact nature of which must depend on his own conception of how his muscles would behave if they were paralysed, fails to show these signs. But if the hysterical hemiplegia was suggested by an organic hemiplegia, these signs would be present, as the patient would be trained by his own organic symptoms to maintain them in an unaltered form when they were no longer organic. Thus, while the upper part of the face is unaffected, the lower, including the platysma (Babinski's platysma sign) would be paralysed, and Babinski's pronation sign and the combined flexion of the thigh and pelvis (Babinski's "second sign") would be present. In the same way the characteristic posture of the arm and leg in organic hemiplegia would be perpetuated. We thould thus be face to face with a case, following an injury or disease which is known to result in organic hemiplegia, and

in which incontestible physical signs of organic disease, such as the extensor plantar reflex, as well as the characteristic posture and the accessory signs described by Babinski and others, are present, although the hemiplegia is entirely hysterical. Such cases can only be diagnosed by experimental psychotherapy. If, as occurred in numerous cases under our care, more or less complete recovery takes place — although, of course, the permanent physical signs of organic hemipelgia persist—it is clear that the paralysis is almost entirely hysterical, although grafted on an organic basis.

The old method of diagnosing between organic and hysterical paralysis thus breaks down, as the physical signs of organic disease do not, as is too often assumed, indicate that the paralysis is entirely organic, but simply that there is an organic element in the case, which may be quite insignificant in proportion to the hysterical. Moreover, it is no help in such cases to consider whether the patient is or is not neurotic, as the large majority have no personal or family history of neuroses, and are in every way normal except for the particular symptom from which they are suffering. No more powerful suggestion of hysterical paralysis could be imagined than organic paralysis, and no abnormal degree of suggestibility is necessary for its development.

We have seen cases of homonymous hemianopia, which is commonly regarded as always organic, persistent headache, amnesia, and epileptiform convulsions develop after head injuries; paraplegia and persistent incontinence of urine, after spinal injuries; paralysis and anæsthesia after nerve injuries in the exact distribution of the nerves, the anæsthesia even resulting in accidental burns; all of which were primarily organic and showed the characteristic features of symptoms caused by an organic lesion, although the recovery with psychotherapy proved that they were hysterical. In many cases, of course, recovery was incomplete, the proportion of hysterical to organic incapacity depending on the extent of permanent damage done to the nervous tissues.

In the same way we have found that the well-recognised association of hysteria with disseminated sclerosis is even more common than is generally supposed, that an hysterical element is frequent in tabes and may occur in such a disease as Friedreich's ataxia. A soldier suffering from the latter disease, who had been unable to walk or stand without assistance and had been unable to feed himself or write for several months, improved to such an extent as a result of a week's psychotherapy that he was able to walk steadily and use his hands for all ordinary purposes, although, of course, the physical signs remained unaltered and the ultimate prognosis is as hopeless as before.

We believe that the same principle should be applied to all organic disease, whatever part of the body is affected, and that the possibility of an hysterical and therefore removable element should be considered, however normal the mentality of the patient may appear to be. Our experience further shows that the ideal method of treatment in such cases is a rapid one—by explanation in language suited to the intelligence of the individual, combined, when necessary, with persuasion and re-education.

Appointments.

I.M.S.

Capt. W. R. Ransford, 1st Batt., 11th Gurkha Rifles, N.W.F.F., to be Act. Major whilst second in command of a Battalion in the Field.

R.A.M.C.

Major A. W. Gater to be Act. Lieut.-Col. whilst commanding a medical unit.

Civil.

District Medical Officer.—A. G. Osburn, D.S.O., M.B. (Windsor Union).

Owen Richards, C.M.G., D.S.O., F.R.C.S., M.Ch., Director of the Egyptian Government School of Medicine and Karr el Ainy Hospital, Cairo, vice H. P. Keatinge, C.M.G., F.R.C.S., resigned.

H. S. Wacher, late Capt. I.M.S., T.C., to be Honorary Surgeon to the Kent and Canterbury Hospital in succession to the late Sidney Wacher.

A. Sandison, B.Sc., B.A., M.B., to be a Deputy Commissioner of Medical Services, Ministry of Pensions, London Region.

There is still time to send in your name for the Biennial.

Guy's Hospital War Memorial.

	£	s.	d.
Brought forward	4,755	14	10
Howe, J. C. Campbell	3	3	0
Bastard, H. R.	2	2	0
Pearce, H. Garfield	1	1	0
Leeming, A. Norman	2	2	0
Ferguson, Miss F.	1	1	0
Swan, R. H. Jocelyn	10	10	0
Mullen, R.	3	3	0
Wright, J. Snarey	2	2	0
Pallant, H. Arnold	2	2	0
Berncastle, H. M.	1	1	0
Mullally, G. T.	5	5	0
Alexander, K. B.	10	10	0
Alexander, Mrs.	5	5	0
Holman, F. K.	5	5	0
Young, Frederic C.	3	3	0
Fagge, R. Hilton	2	0	0
Cook, Frank	2	2	0
Glanville, L. S. H.	5	5	0
Oxford, Miss M. N.	2	2	0
Wakefield, C. F.	1	1	0
Wilkinson, J. Cooper	5	5	0
Goldie, E. G.	3	3	0
Haughton, Miss L. V.	2	2	0
Stewart, Walter G.	2	2	0
Ewart, J. H.	2	2	0
Kidman, G. E....	3	0	0
Cole, Percival P.	10	10	0
Smith, T. H.	2	2	0
Creasy, Rolf J.	1	1	0
Keele, Stephen	5	0	0
Dawson, W. J. O.	1	1	0
Burton, Miss F. M.	1	1	0
Davy, Sir Henry	5	5	0
McNair, A. J.	3	3	0
Jabir, S. M.	1	1	0
Morton Palmer, A. S.	1	1	0
Douglas C. Gordon	1	1	0
Moore, J.	2	2	0
Bedford, Godfrey H.*	5	0	0
Woodruff, K. M.	1	1	0
Lulham, E. L....	1	1	0
Bamber, H. E.	3	0	0
Spong, H. G.	3	3	0
Miller, A. H.	2	2	0
Salt, H. O.	5	5	0
Officers and Servants of Guy's Medical and Dental Schools and College	8	14	0
"E. P. M." per Editor of Guy's Hospital Gazette	2	0	0
Boniface, Miss N.	3	3	0
Thomson, G. Y.	10	10	0
Hopon, M. Fred	3	0	0
Eddeson, H. W.	15	0	0
Leader, H.	1	1	0
Carter Braine, J. F.	3	3	0
Gardiner, J. N.	0	5	0
Steinbach, Horace	2	2	0
Hinde, Ernest B.	3	3	0
Williams, R. E.	2	2	0
Norton, E. L.	1	5	0
Lowe, William E.	1	1	0
	£4,955	2	10

* First annual instalment in respect of total contribution of £25.

Notices.

Guy's Hospital Medical School.

September–October, 1919.

The following Entrance Scholarships have been awarded:—

Senior Science Scholarships for University Students.—£75. Arthur Henry Douthwaite, University College, London.

Junior Science Scolarships.—£120. Thomas Stephenson Blacklidge, Preliminary Science Class, Guy's Hospital Medical School. £50. Williams Gordon Sears, Preliminary Science Class, Guy's Hospital Medical School.

Scholarships in Arts.—£60. Donald Fraser Durward, St. Olave's Grammar School. £40. Oswald Fred. Farndon, Rhyl County School.

The following Scholarships have been awarded:—

Open Scholarship in Dental Mechanics.—£20, equally divided. J. H. Broadhead and F. J. Farmer.

Pupils' Scholarship in Dental Mechanics.—£20. P. N. Conway Jones.

Lantern Demonstrations.

Mr. Todd will show slides from the Hospital Collection, in the Anatomy Theatre, at 5 p.m. on Fridays. The Collection includes skiagram of normal bones and joints, skiagrams of a number of fractures, and other pathological conditions; and also photographs of various interesting cases.

The Demonstrations will be quite informal, and are open to any students and members of the Nursing Staff who care to attend.

First Demonstration: 17th October.

Guy's Hospital,
13th October, 1919.

Messrs. E. & S. Livingstone, Edinburgh, have in preparation for publication in the autumn, two new books, viz.:—"Handbook of Anæsthetics," by John Stuart Ross, M.B., F.R.C.S., and "Handbook of Skin Diseases," by Frederick Gardiner, B.Sc., M.D., F.R.C.S., and about the same time they hope to issue the second edition of Dr. Jas. Burnet's "Manual of Diseases of Children." In each case they hope to publish at about 7s. 6d. net.

Extracts from the Letters of a London Medical Student.

London, February 26th, 1818.

. . . . Where ever I may finally pitch my tent, I never can hope to experience more kindness than I have received from my friends in town. To literary society, I must in a great degree bid good-bye, and perhaps few have enjoyed that more than myself. Almost invariably, I have gone home with Mr. Travers and Mr. Allen after their lectures, and have learnt almost as much from their conversation as from the lectures themselves. From the time of my coming to town, Mrs. Travers of Swithin's Lane, aware that the friendship of their relation would be of service to me, took every opportunity to impress him with a favourable opinion of me, and he afterwards speaking well of me to them, I stand pretty high in the good graces of both, and consequently when Mr. T. Senior has any of his literary friends with him (and he has a tolerably large circle of them), I am generally invited to make one of the party . . . . . .

There is a bill now going through the House to regulate the practice of Surgeons. It has been read a second time, and there is little doubt of its passing. Its main object is to prevent any persons practising in future as Surgeons, except Members of the College; of course not affecting those already in practice. I understand it also lays a very considerable Stamp duty on the Indentures of Apprentices, compels a longer attendance on the practice of a Hospital than is now required previous to an examination for the Diploma, and some other clauses calculated to increase the respectability, and, after a time, the practice of those who are already in the profession, by preventing the supply from exceeding the demand, as it has hitherto done. They intend also, I am informed, to raise the price of the Diploma to Fifty Guineas, besides the Stamp duty. At present the price is Twenty Guineas and a Stamp duty of one Pound. This however probably will not take place while I am in town. At all events, I shall be able to ascertain it from the Master of the College of Surgeons, who is Senior Surgeon to St. Thomas's Hospital. If this last regulation should soon be put in force, of course, I must anticipate it. Otherwise there will be no necessity for going up till May or June. The greater number indeed go up to their examination a considerable time previous to leaving town, partly from motives of vanity, partly to get rid of an awkward kind of fear, which some unpassed students feel at the prospect of appearing before the Dons. With regard to the first, however, I trust I am above the petty vanity of thinking my consequence increased by possessing the Diploma of the College, and as to the apprehension (which I confess does not annoy me much), it is to many a very useful feeling. I have seen many an attentive pupil change in one night into a lazy "Member of the Royal College of Surgeons."

You will be surprised to learn that I have after all been disappointed in the Prize of the Physical Society. The cause I understand to be that the funds of the Society being low, and the other question being contested, they were unwilling to give a prize to a paper which had no competitor, and this resolution was accordingly carried in the Committee by a majority of one vote.

(*Concluded.*)

Change of Address.

Surg. Com. A. Thomas, 5, Southsea Terrace, Southsea, Hants.

G. T. Foster-Smith, M.B., B.S., the Anglo-Saxon Oil Co., Miri, Sarawak.

J. W. Greenwall, L.D.S., 1, Moray Place, off Breda Street, Cape Town, S.A.

Surg. Capt. Robley Browne, O.B.E., R.N., 143, Church Lane, Old Charlton, S.E. 7.

C. P. Symonds, 58, Portland Place, W. 1.

Capt. R. C. Matson, Burntwood, Boileau Road, Ealing, W. 1.

Miss F. S. Cox, Ferny Bank, Willaston, Nantwich.

A. M. Zamora, M.Ch., F.R.C.S., 12, Welbeck Street, W. 1. (Tel. Padd. 4298.)

Ralph B. Cannings, 5, Ermine Road, Lewisham, S.E.

J. F. Venables, 65, Elsham Road, Kensington, W. 14.

E. G. Slesinger, O.B.E., M.B., F.R.C.S., 10, Lauderdale Mansions, W. 9. (Tel. Hampstead 5817).

D. H. Forty, Lincoln Lodge, Sands Road, Paignton, S. Devon.

G. Black, M.B., B.S., Halifax Lodge, Hurstpierpoint, Sussex.

Capt. F. D. Annesley, R.A.M.C., R.A.M.C. Mess, Peschawar, North West Frontier Province, India.

W. L. Chubb, M.D., Winkleigh, N. Devon.

L. Horsley, 140, Marylebone Road, London, W.

D. R. Hate, Charni Road, Girgaon, Bombay, India.

M. B. Velkar, Ajiari Road, Bombay, India.

Correspondence.

To the Editor of Guy's Hospital Gazette.

THE BIENNIAL DINNER.

October 28th, 1919.

Dear Mr. Editor,—I am much obliged to you for inserting my previous letters about the Biennial Dinner. I now send you the list of those who have, so far, signified their intention to be present. Dinner tickets will shortly be sent to all those whose names appear in the accompanying list, and I would ask everyone to return to me *immediately* the notice accompanying the ticket as therein requested. If this is done I hope to be able to arrange that each diner will find himself seated among his own particular group of friends. On the other hand, it will be impossible for me to carry this satisfactorily into effect in the case of those whose replies reach me later than the evening of Thursday, Oct. 23rd. Of course, if there are any Guy's men who have been unable, so far, to decide to come, and yet find that at the last they can do so; or if there are any who, on looking over the accompanying list see names which induce them to come, I hope they will apply to me *at once* for a seat, informing me in their letter near whom they would like to sit. I will then do the best I can for these late comers, who, though late in applying, will be none the less welcome.

I am, Sir,
Yours sincerely,
98, Portland Place, W.1. F. J. STEWARD.
Oct. 17th, 1919.

LIST OF GUY'S MEN WHO HAVE SIGNIFIED THEIR INTENTION TO ATTEND THE DINNER.

1854—1869 (inclusive).

1854 Dixon, J.
1863 Ray, E. R.
1864 Savage, Sir G. H.
1868 Higgens, C.
1869 *Durham, F.

1870—1879 (inclusive).

1870 Matcham, A.
Murphy, Sir Shirley
1875 Brown, T.
Elcum, Lt.-Col. D.
1875 Miles, Lt.-Col., M.E., C.B.E.
*Symonds, Sir C. J., K.B.E., C.B.
1877 Lane, Sir W. A.
Mansell, E. R.
Wilkinson, J. C.
1878 Beale, E. Clifford
1878 Lynn, E.
1879 Howell, T. A. I.
*White, Sir W. Hale, K.B.E.

1880—1889 (inclusive).

1880 Ashwell, Lt.-Col. H. G., R.A.M.C.
Cameron Smith, J.
Gosse, H. W.
1881 *Blatherwick, H.
Milligan, R. A.
Pitt, G. Newton
1882 Gibson, J. H.
Hind, W.
Sells, H. T.
1883 Floyer, W. W.
1884 Counsell, H. E.
Humphreys, Major F. R., R.A.M.C.T.
Tubby, A. H., C.B., C.M.G.
1885 Creasy, Rolf
*Farr, E. A.
Goodall, E. W.
Perry, Sir E. C.
Price, A. E.
1886 Alexander, S. R.
1886 Beard, F.
Burghard, F. F., C.B.
1887 Browne, R.
Brownfield, H. M.
Bryden, F. W. A.
Cruikshank, J. W.
Holloway, S. F.
Randall, P. N.
Routh, C. F.
1888 Collington, F. A.
Holman, F. K.
1888 Marriott, Surg.-Capt., H. B., R.N.
Norburn, A. E.
Roberts, J. L.
Smith, G. Bellingham
1889 Fripp, Sir A. D., K.C.V.O., C.B.
Lansdown, R. P.
Price Jones, C.
Rouw, R. Wynne

1890—1899 (inclusive).

1890 *Fawcett, J.
Long, D. S.
*Richards, J. S.
Spurrell, C.
Stevens, T. G.
1891 Craig, M.
*Daldy, A. M.
Hopson, M. F.
Jewell, J. W. F.
Salter, C. E.
1892 Bolus, H. B.
Carling, W.
Dixon, W. H.
Fisher, W. H.
Floyd, S. G.
Jackson, T. S.
Ralph, C. H. D.
Sheen, A. W.
Turner, F. M.
1893 Collier, H. W.
Cooper, H.
Edwards, F. H.
Eyre, J.
*Jewell, W. H.
Pearce, A. Chaning
Pendred, Vaughan
Still, G. F.
Wilson, F. W.
1894 Allan, A. P.
Allport, A.
Carpmael, C. E.
Duffett, H. A.
*Hopkins, F. G.
Mawby, F. W.
Phillips, R. E. G.
Reid, E.
Robinson, W. E.
1895 Ensor, C. A.
1895 Handley, W. S.
Hayes, R.
Hovenden, A. C.
Hovenden, G. S.
Partridge, A. H.
*Shorland, E. T.
Steward, F. J.
Stewart, H. M.
1896 Busteed, J. H.
Edwards, C. D., M.C.
Ensor, J. W.
Fagge, C. H.
Michael, C. E.
Millbank-Smith, H. J. M.
Ormond, A. W.
Spicer, A. H., M.C.
Spon, H. J.
1897 Bruce, H. W.
1897 Cardin, H.
Cloud, F. H. L.
*Fremantle, F. E.
Wakefield, C, F.
Way, M.
1898 Dowsett, E. B.
*Eason, H. L., C.M.G.
Henson, W. J.
Jones, J. H.
McGavin, L. H.
Swan, R. H. J.
Turner, P.
1899 Berncastle, H. M.
Curtis, P. J.
Kirkman, A. H. B.
Miller, A. A.
*Payne, J. L.
Penrose, A. W.

1900—1909 (inclusive).

1900 Brydone, J. M.
Camps, P. W. L.
French, H., C.B.E.
1902 Shipway, F. E.
1903 Bridger, J. D.
Goldie, E. G.
1905 Dismorr, C. J. E.
Edridge, R.
French, R. E.
1907 Flower, N.
*Henderson, H. J., M.C.

Goadby, K.
Goble, E. W.
Hicks, C. E.
*Nicholls, F. J.
Parrott, H. McD.
Shufflebotham, F.
Steele-Perkins, J. S.
Taylor, J. G.

1901 Atkins, Sir J., K.C.M.G.
Bowen, W. H.
Cross, F. G.
Gray, A. C. H.
*Greenfield, D. G.
Hammond, J. A. B.
Hardenberg, E. J. F.
Manfield, G. H. H.
Tilbury, R.
Wacher, H.

1902 Cutler, H. A.
Morland Smith, T.
Pinching, C.
Robinson, James F.
Mann, H. C.
Pye-Smith, C. D., D.S.O., M.C.
Robinson, G.
Spriggs, N. I.
Tipping, H.
Wallace, F. H.

1904 Alcock, F.
Beaumont, A. R.
Benett, A. M.
Bradbury, J. C. O.
*Cole, P. P.
Cowper, C. M. L.
Hughes, E. C.
Hurst, A. F.
Mollison, W. M
Routley, E. W.
Stevenson, C. M.
Ticehurst, G. A.

1905 Bellingham-Smith, E.
Cameron, H. C.
Clarke, H. M.
Crofts, A. D.
Palmer, F. W. Morton
Payne, O. V.
Sheaf, E. W.

1906 Alcock, A.
Burney, Capt. W. H. S.
*Davies-Colley, R., C.M.G.
Fothergill, C. F.
Goodhart, G. W.
Layton, T. B., D.S.O.
Malleson, H. C.
Ripman, C. H.
Stebbing, G. F.
Trethowan, W. H.

1907 Aubrey, H. P.
Barnett, E. P.
Carlill, H.
Druitt, D. C.
Vandermin, H. F.
Wyatt, H. D.
Zorab, A.

1908 Chapple, H.
Crook, A. H.
Dawson, R. B.
Johnson, W.
Palmer, A. S. Morton
Price, P. S.
Stott, H.

1909 Attwater, H. L.
Bromley, L.
Collins, E. A.
Ledlie, W.
Lee, H.
Jones, C. E. M.
Laidlaw, P. P.
Munden, W. P. H
Ryffel, J. H.
Sheppard, A.
Visick, H.
Watson, J. N.

1910—1919 (inclusive).

1910 Barber, H. W.
Cox, A. Neville
Dunderdale, G.
Fox, W. E.
Gardiner, H.
Hunt, G. H
Kidd, W. S.
Munden, M. M.
Poulton, E. P,
*Saner, F. D.

1911 Cook, F.
Glendining, V.
Hind, G. R.
*Marshall, G.
Mullally, G. T.
Mutch, N.
Pryce-Davis, J.
Sandison, A.
Slesinger, E. G.
Todd, A. H.
Warner, H. P.

1912 Bennett, T. I.
Eccles, G. D.
Garrard, N.
George, W. S.
Hoby, H. J.
Reynell, W. R.
Smith, P., M.C.
Soothill, V. F.
Stewart, J. L.
Stringer, L. D.
Zamora, A. M.

1913 Bevan Brown, F.V.
Creasy, R. (Junior)
Fry, W. K.
Moberly, A. V.
Ogilvie, Capt. W. H., R.A.M.C.
Perceval, J. L.
Roberts, C. S. L.
*Ryle, J. A.
Scott, E. D.
Tanner, W. E.
Venables, J. F.

1914 Bull, F. B.
Dean, C.
Lambrinudi, C.
Messenger, H. L.
Muir-Smith, L.
Pedley, C. F.
Smith, C. R.
Stallman, J. F. H.
Young, W. A.

1915 Attwater, G, L.
Biddle, E.
Coffin, S. W.
Curle, R.
Lloyd, V. E.
Price, H. Parry
Reynolds, W. L. E.
Sells, R.
*Bates, K. L.
Eccles, H. N.
Heckels, G. W.

1917 Joffe, J.
Woodruff, K. M.

1918 Crook, F. W.
*Debenham, L. S.
Lyne, L.
*McKay, W. K.

1919 Bonar, T. G. D.
Brown, H. M.
Cellier, W. H.
Hay, W. G.
Kendall, J.
Ledlie, C.
Lindsay, G. P.
O'Meara, D. J.
Patterson, R. M.
Remington, W.
Rosenberg, I.

Cock, Stanley

Lowry, Prof. T. M., F.R.S.

* Vice-Chairmen. † Date of Qualification.

Also Viscount Goschen, Mr. Cosmo Bonsor, Major Oswald Magniac, Mr. Francis P. Whitbread, and the Editor of the GUY'S GAZETTE.

DEAR SIR,—With reference to the Passim note in the last number of the GAZETTE regarding specimens in the Gordon Museum, I beg to point out that before the War there were 1,800 specimens preserved in spirit. During the Air-raids these were removed and the spirit replaced by formalin. 1,400 of these have now been remounted in this manner and are therefore practically clean and air-tight.—I am, dear Sir, Yours faithfully,

H. A. HUNT.

October 14th, 1919.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette." Guy's Hospital, London, S.E.*

Guy's Unit "M" Division.

Special Constabulary.

An appeal was made on October 1st for special constables to be enrolled from among the students. Swearing in began at 10 a.m. on October 2nd, and within an hour between one and two hundred had taken the oath. The unit was organised into four groups each of five squads of ten police constables under a sergeant, the groups being under a sub-inspector. "A" group consists of men living in the college or in the neighbourhood, and is completed by men in the wards who do not live in; group "B" is formed of dental students; group "C" from junior medical students; and group "D" from both medical and dental students.

Group "A" affords a body of men upon whom a call may be made at short notice, the other three groups being instructed to come up in rotation ready to stay the night if necessary.

On Saturday a call was made upon the services of the unit to provide constables from mid-day to mid-night, some 50 men were provided on Saturday, and 60 on Sunday, each man doing a turn of four hours duty.

The organisation which includes a head-quarters consisting of a chief inspector, a sub-inspector, and a sergeant in being retained in case of further need; there are a few vacancies open, and any student who wishes to join should give his name to sub-inspector Winston in the Library.

Birth.

NEVILLE-COX.—On Oct. 4th, at 21, Cornwall Gardens, Brighton, to Dr. and Mrs. A. Neville-Cox—a daughter.

Marriages.

WACHER—STRINGER.—On Sept. 3rd, at St. John's, Cowley, by the Rev. J. P. Frend, uncle of the bridegroom, Herbert Stewart, son of the late Sidney Wacher and Mrs. Wacher, of Canterbury, and Nellie Matilda, daughter of Mr. and Mrs. Stringer, of Cowley, Oxford.

EASTES—MOORE.—On Oct. 4th, at the Parish Church, Leatherhead, George Leslie Eastes, M.B., B.S., of Harley Street, W., to Margaret Emily, only child of Mr. and Mrs. A. H. Moore, of Leatherhead.

HORSLEY—GORDON.—On Wednesday, Oct. 1st, at Christ Church, Clifton, by the Ven. Archdeacon Talbot, D.D., assisted by Rev. H. T. Dixon, D.D., Launcelot Horsley, M.R.C.S., L.R.C.P., younger son of Dr. Henry Horsley, of Croydon, to Grace, younger daughter of Geo. Gordon, Esq., of Bristol.

The Sciences.

BIOLOGY.

The Biology course is primarily intended to be the students' introduction to the science of medicine, and must be regarded as the study of living things in many forms and from various aspects rather than the acquisition of facts about a number of plants and animals. In other words, it is intended as a training in the acquisition of a point of view rather than a stock of facts. Incidentally, also, the student learns a language which is largely his means of expression afterwards. The practice of the Biological Laboratory should give him a facility in the use of scalpel and scissors and a knowledge of methods of preparation and staining of tissues which are the arts of the Dissecting Room and the Histological Laboratory.

Lastly, a thorough acquaintance with the vertebrate types should be a great help to him in obtaining an intelligent knowledge of human anatomy. Cases of instruments are placed on view which include all those afterwards required in the Dissecting Room.

A microscope is needed from the beginning, and the student is warned against buying an instrument which will be a handicap to him throughout his career. The difference in price between a good and a bad instrument is only a few pounds. All second-hand microscopes should be submitted to the Demonstrators for inspection and examination of lenses before the purchase is completed.

CHEMISTRY AND PHYSICS.

The student is often tempted to regard the study of Chemistry and Physics as one of very little use when once his preliminary examination is passed; but he will find in his study of the sciences of Physiology, Pharmacology and Pathology that a proper understanding of Chemistry and Physics is invaluable and essential. That this is so, is now fully recognised in the curriculum of the London University which should be carefully studied by every London student.

The matriculated student will, in his first year, study Inorganic Chemistry, Physics, and General Biology, and at the end of this period, provided he has worked diligently in the laboratories, and attended the lectures and revision classes regularly, should have no difficulty in passing the First Examination for Medical Degrees. In his second year he will study Organic and Applied Chemistry, together with Anatomy and Physiology, and at the end of the second winter, provided, as before, that he has worked steadily from the commencement, should have little difficulty in passing the First Part of the Second Examination for Medical Degrees. Anatomy, Physiology, and Pharmacology are then taken as the Second Part of this Examination, at the close of the third winter, prior to commencing clinical work in the wards.

From the Conjoint and the Dental student only six months' work is required, but those entering without previous knowledge of Chemistry and Physics will find that time hardly sufficient, and are usually advised to take the full "year" of three terms, or nine months.

The importance of practical work cannot be too greatly emphasized, and lectures and books can but supplement work done in the laboratory. Guy's men have no excuse for neglecting laboratory work. The Chemical Laboratory, for example, is open from 9 a.m. to 5 p.m. on Mondays, Tuesdays and Wednesdays, and from 9 a.m. to 6.30 p.m. on Thursdays and Fridays, and students are strongly urged to form early the habit of spending their spare hours, apart from those officially allotted, in one or other of the laboratories. Reading should be left for the evening. After a day in the laboratory, reading a good text-book will be found to give ample scope for thought. "Cramming," or the memorising of words and phrases, without a knowledge of the corresponding realities, is one of the worst intellectual habits a student can acquire, and in the long run invariably leads to failure.

ANATOMY.

The primary object of dissecting is to render oneself familiar with the structures of human anatomy and their relationships one to another. A good knowledge of human anatomy is essential to the medical student, owing to the great scope for application of this knowledge which is provided by medicine and surgery, and it is no exaggeration to say that the better a man knows his anatomy, the more likely is he to succeed in either of these subjects. By handling and tracing the structures exposed in dissections, the student is enabled to form mental pictures which greatly exceed in value the plates and diagrams to be found in books, and it cannot be emphasised too much that the knowledge obtained by dissecting is more thorough, more lasting and more definite than the knowledge obtained from text-books, however good the latter may be.

In addition, dissecting trains the fingers and develops the sense of toueh, and that delicate muscle sense which is so necessary to aid the eye in carrying out a delicate manipulation.

The basis of anatomical knowledge is a thorough acquaintance with the bones. These can only be learnt by handling the bone and making out each point on it as the description in the book is being read. Hence it is absolutely essential to possess a half skeleton. (This may be had from Mr. Hancock, the Senior Assistant in the Anatomical Department, who will also supply cases of instruments.)

The man who sits in an easy chair with an open Gray upon his knees and no bones by his side is simply wasting his time.

Men who intend to take the Primary Examination for the Fellowship of the Royal College of Surgeons should attend both the course of lectures for senior students in the second winter session (for times, *vide notices*), and also the special class for the Primary Examination.

Books and Instruments.

The student requires a Manual of Practical Anatomy, in which the structures are described as they are exposed in the course of dissection. The best book for this purpose is Cunningham's Practical Anatomy (2 vols., 12/6 each); it should be read before, during, and after each day's work.

In addition, a text-book of Human Anatomy, in which the subject is described by systems, is necessary. Gray's or Cunningham's Text-Book are both good.

Men who think that they may want to take the Primary Examination for the Fellowship of the Royal College of Surgeons will require a book dealing with Embryology and Morphology, and they will find that Keith's book on the subject contains all that is essential.

The following instruments are necessary:—Three scalpels, two pairs of *dissecting* forceps, and two sets of "hooks." No other instruments are necessary.

Dental Students.

The detailed knowledge which is demanded of the medical student is essential from the dental student only as regards the head and neck and the bones of the skull. Special demonstrations are arranged each term suitable to the requirements for the L.D.S. Examination. Dental students should arrange their curriculum in such a way that the three terms which they are required to spend in the dissecting room are consecutive. The disadvantages of breaking up the course are very obvious, and quite outweigh any apparent temporary advantage that may accrue from doing so.

PHYSIOLOGY.

Physiology, which forms the basis upon which scientific medicine and surgery rest, will require the most earnest attention on the part of the student during the short space of two years which he can devote to it, and he will find that his understanding of the medical, surgical and pathological problems with which he will meet later on varies directly with the thoroughness of his physiological ground work. While attendance at physiology lectures and the reading of some elementary work on the subject, such as Huxley's *Elementary Lessons in Physiology*, or the smaller works by B. Moore and by Foster and Shore, during the first year is undoubtedly useful, yet for most men the practical study of Physiology begins in the first summer session. During this session he attends the classes in Practical Histology which are held three times a week, and for which he will need a microscope, certain mounting materials, and Schäfer's *Essentials of Histology*, which should be carefully studied.

During the first summer session and the first half of the second winter session the student should attend the lectures on Physiology (for times, *vide* notices), and also the tutorial classes which are held by the demonstrators. During this time he should read the subject in some text-book such as Starling's *Principles of Human Physiology*, Halliburton's *Handbook of Physiology*, Stewart's *Manual of Physiology*, Howell's *Text-book of Physiology*, or Hill and Flack's *Text-book*. While attending the practical classes held during the winter, the student is advised to read *Practical Physiology* (published by Arnold).

Candidates for the M.B. of London or other Universities must in addition attend the class in advanced practical physiology held twice a week during the second winter session, and this class should also be

attended by men working for the first F.R.C.S. examination.

Those desirous of obtaining distinction in the second M.B. examination should supplement the course of reading indicated above with original papers in the *Journal of Physiology*, with parts of Schäfer's *Textbook of Physiology*, *Recent Advances in Physiology and Bio-chemistry*, edited by L. Hill; *Further Advances in Physiology*, edited by L. Hill; and Leathes' *Problems in Animal Metabolism*. Revision classes are held by the Demonstrators during the two months preceding the first F.R.C.S. and the M.B. examinations and should be attended by all candidates.

PROBATIONARY CLINICAL COURSE.

On the completion of his studies in Anatomy and Physiology, the student enters on the first stage of the clinical curriculum and holds a Preliminary Clinical Appointment. The duties of this appointment involve attendances in the Laboratories of Pathology, Bacteriology, and Pharmacology, as well as in the Post-mortem Room and in the wards.

By attention to the laboratory work, the student continues his researches in Physiology and Anatomy, applying them to conditions which are pathological, and he will acquire a sound knowledge on which his understanding of conditions of disease may be based.

The laboratory work is combined with an introduction to clinical work, and, in addition to regular attendances in the post-mortem room where an enormous amount of medicine and surgery may be learnt, the student takes a share in the clinical material available in the wards, both medical and surgical. A portion of the weekly programme is devoted to what is styled "Elementary Clinical Medicine and Surgery," in which the student is brought in contact with the patients in the wards and at Out-Patients, learning Case-taking, Examination of Patients, Physical Signs, Reporting on Cases, and Principles of Treatment.

The student is strongly advised to devote himself earnestly to the laboratory work in order to equip himself so that he may obtain the greatest possible benefit from the clinical work presented to him during this period and later throughout the clinical curriculum. He is further urged to associate himself with a Firm, both medical and surgical, and to take advantage of the surgical take-in week of the Firm, when he can make himself useful in a variety of ways.

From the commencement of his clinical studies the student must be "signed up" for each appointment that he holds. That is, a brief report on his work is made by each of his teachers at the end of the appointment. This report is concerned especially with his keenness, punctuality, and ability. These reports are then filed in the Medical School Office and consulted when he applies for other appointments. In the later stages of the clinical course when competition becomes keen for a limited number of appointments, and more especially when application is made for house-appointments the student's record as shown by his "signing up" is the chief factor in the allocation of the posts. So it behoves every man who desires to get the best out of his time in the wards to ensure that he is well "signed up" for every appointment from Clinical Probationer onwards.

PATHOLOGY.

When the student has passed the Second Conjoint or M.B. Examination he is about half-way through his medical curriculum, and he should have gained a working knowledge of the functions of the body in health. This knowledge is an essential preliminary to the study of the most important of the medical Sciences, viz., Pathology, or the study of the functions of the body in disease. Throughout his life the student, if he continues to study and practise medicine, must ever keep pathology in the foreground. It is desirable, therefore, that the study of pathology be begun as soon as possible and continued throughout a medical career.

The subject is an exceedingly large one and it is customary to divide it into several sections:—

1. General Pathology.
2. Morbid Anatomy.
3. Morbid Histology.
4. Bacteriology.
5. Chemical Pathology.

Due attention must be paid to each of these branches.

In the new arrangement of studies a course in elementary pathology has been designed to form the precursor to the full clinical appointments. During this course elementary instruction is given in the various branches of pathology enumerated above, together with the essential points in case-taking in Medicine and Surgery. Three mornings a week (Tuesday, Wednesday, Thursday) will be occupied with lectures on the general principles of pathology including bacteriology, followed by practical work in morbid histology and bacteriology. Monday and Friday mornings will be devoted in part to chemical pathology and in part to minor medicine and surgery. Two afternoons are set apart for morbid anatomy in the post-mortem room, and two afternoons to clinical work. This course must be attended by every man as soon as he has passed his second medical examination.

At the end of this course, the foundations of scientific medicine should have been laid, and if well and truly laid, the superstructure should be comparatively easy to complete.

It is essential that throughout all ward appointments no opportunity should be missed of continuing the study of pathology. Every man should, as far as is practicable, follow out the pathology of each and every one of his cases. Is a bacteriological investigation made? He should follow it as far as possible. Is a portion of tissue removed for microscopical examination? He should see the section. Is a chemical examination demanded? He should try and see the analysis carried out. He should never miss an autopsy on any one of his cases. He should read up each case as he meets it. Set hours cannot be given for these lines of study, they must be fitted in as time and opportunity permit.

Efforts should be made to see as much practical work and as many demonstrations in pathology as can be arranged. There are very few days when no pathology can be learned. Post-mortems are held nearly every day — Monday, Tuesday, Wednesday, Thursday and Friday at 2 p.m., and Saturday at 12

noon. Attendance at these will amply repay the time expended.

Informal classes in pathology are held twice weekly during the October and May terms (Monday and Friday at 9.30 a.m.). These, though primarily intended for M.B. students are suitable for all and should be attended by those sitting for Part I. of the M.B. Cantab. and the Final M.B. of Oxford or London University.

Classes and demonstrations in chemical pathology should be attended during the tenure of the post of Medical Ward Clerk. Lectures in Pathology, Bacteriology, and chemical Pathology should be put in as time, inclination, and opportunity permit.

During the later clinical appointments certain students may hold a few pathological posts, such as Student Demonstrator, Assistant to the Demonstrators of Morbid Anatomy, Student Assistant in the Bacteriological Department. One or more of these may be held in turn, and they prove exceedingly valuable from the learners' point of view.

There are many books which might be recommended, and what suits one man does not prove attractive to another. MacCullum, "Text Book of Pathology"; Pembrey and Ritchie, "General Pathology"; with Muir and Ritchie, "Manual of Bacteriology," should prove an adequate combination for most purposes. Other books which may suit other tastes and which are good are—Adami, "Principles of Pathology"; Adami and Macrae, "Text-book of Pathology"; Green, "Pathology." For morbid histology Grunbaum "Essentials of Morbid Histology" may be recommended.

When the information in these books proves inadequate, as it is sure to do occasionally, some of the articles in Allbutt and Rolleston "System of Medicine" may be consulted, or references to original papers may be obtained from that work, and from the bibliography in MacCallum, "Text-book of Pathology."

BACTERIOLOGY.

From the preceding paragraphs it will be seen that elementary practical instruction forms part of the work of the newly instituted Probationary Clinical Appointment, and as such is intimately associated with clinical medicine and surgery, on the one hand, and post-mortem study, on the other. From the student's point of view microscopical pathology now occupies some 120 hours compressed into an appointment of three months' duration instead of being extended over a period of six months, and more stress is laid upon the correlation of microbic activity and histological changes.

Bacteriology, although one of the youngest of the auxiliary sciences, has already made a most profound impression upon the theory and practice of both medicine and surgery, and by providing appropriate and specific treatment for bacterial infections has created the demand for exact as well as accurate diagnosis. Consequently, particular attention is devoted in this class to the technique of the various investigations undertaken in connection with the ward work. The student himself stains sputum, pus, and morbid exudates by various methods to demonstrate the associated bacteria. In addition, he is instructed in the practical work of culture and staining methods, and is encouraged to repeat for himself during the intervals between successive classes any observations and experiments previously carried out, in order that he may be adequately prepared to take advantage of the advanced courses which are available during later years of study, and to equip him for the performance in general practice of those more obvious methods of bacteriological diagnosis, which experience has shown are both reliable and valuable. Demonstrations are also given upon the life history of the various organisms pathogenic to the human race and the changes such organisms undergo or produce when they gain entrance to the human tissues.

During February and March of each year a course of lectures is given dealing even more specially technically with the applications of bacteriology to practical diagnosis and treatment. These should be attended at a somewhat later period, since they deal with the various remedial agents (serums and vaccines) which have been elaborated in the bacteriological laboratory for the treatment of disease, together with those facts and theories relating to natural and acquired immunity upon which bacteriological therapy is based.

MEDICAL WARDS.

To each medical ward clerk is allotted a certain number of beds, and he is expected to examine, and write full reports on all patients who are admitted into these. Occasionally it so happens that a patient is too ill to be examined except by the house-physician and physician, or that a case dies or is discharged before the ward clerk has had an opportunity of seeing it. Under these circumstances he should obtain the history, and an account of the symptoms, physical signs, and progress of the case from the house-physician, and should base his report on these data. It cannot be too strongly insisted that a report, however brief, must be written on every case, and it is of the greatest importance that the diagnosis and remarks made by the Physician should be entered at once into the report. Moreover, any errors detected by the Physician or Registrar in the original report should be immediately corrected. In the event of a patient dying the ward clerk must obtain the abstract of the post-mortem findings, and carefully enter it up, and it need hardly be said that all clerks should make every effort to see the post-mortem examination on any case they may have seen during life.

The medical wards are open to clerks from 10 till 12.30 in the morning, and from 1.30 till 5.30 or 6 in the evening. The Registrars begin their rounds at 10.30, and by that time a clerk should at least have full notes of the history of any new patient who may have been admitted into one of his beds; and he should have a full report in readiness for the Physician in the afternoon. Ward clerks should realise that they are expected to know the details not only of their own cases, but of every patient under their Physician. It is no excuse to plead ignorance because "this is not my case." If only a clerk will take the trouble to make himself conversant with each case in this way, he will find at the end of his six months that an enormous amount of clinical material has passed through his hands, and he will probably have acquired enough knowledge of medicine to enable him to pass the Conjoint Final with but little additional reading. But so many men waste their time through sheer laziness in the medical wards, never realising that they are throwing away experience which would prove invaluable to them later on.

An hour spent in the wards after tea three or four times a week will give opportunities, not only for going over cases and writing up reports, but also for seeing the house-physician tap chests and abdomens, etc. The treatment, too, which each case is receiving, may well be studied at this time.

As regards reading, the best method is to study the text-book account of each disease as one comes across it in the wards or in discussion, and afterwards to compare, if possible, the text-book description with the symptoms and signs presented by the patients. At the same time, the most important medical journals should be read regularly, for by this means only can the student keep himself in touch with modern work. The *B.M.J.* and *The Lancet*, as well as the *Journal of the American Medical Association*, are especially recommended.

Books that may be recommended are the following:—The well-known text books by Taylor and Osler, "Medical Diagnosis," by Latham and Torrens (a most valuable work), and "Auscultation and Percussion," by Gee. For second three months ward clerks Dieulafoy's "Text-book of Medicine," the most important monographs in Allbutt's "System of Medicine," and Campbell Thomson's "Diseases of the Nervous System," will prove valuable and interesting reading. For laboratory work Hutchinson and Rainey's "Clinical Methods," or Dr. French's book may be useful for reference.

SURGICAL WARDS.

After three months in the Medical Wards the student gives up a similar period to surgical work. He has already made some acquaintance with this side of the hospital in his probationary clinical course and should be ready to take at once a full share in its activities. In the first place, he is responsible for writing reports on the cases allocated to him, and in this connection he must be careful not to fall into the error of thinking that surgical reports are less important than those on the medical side. In reality the reverse is often the case. It is especially of great moment to the patient that an exact record be kept, since later treatment may be much more or less efficacious according as a good account of previous findings and operations is or is not available. In order to ensure that the reports are properly kept, the hospital authorities have laid it down that the dresser shall go round with his Registrar on those days when he is not on duty in the surgery—the plea that there are dressings to be done in the wards will not be accepted as an excuse.

Secondly, he is responsible for doing the dressings on such of his cases as require it and for such other after-treatment as may be delegated to him. This is a very real responsibility, since any carelessness, especially lapses from strict surgical cleanliness, may endanger the patient's life or greatly prolong his convalescence.

The same responsibility devolves on the dresser when he assists his surgeon at operation, and he will find that all his attention is strictly required to the business on hand if he is to give his surgeon that full assistance which is so necessary for the satisfactory and prompt performance of an operation.

At this time, too, the dresser must take his turn for duty in the Front Surgery, where he works under the supervision of the Out-Patient Officers, and where he is expected to put into practice those rudiments of medicine and surgery he has acquired.

We have only briefly indicated the main points in the work of a surgical dresser. He will receive a copy of the "Standing Orders" relative to this and each other appointment he may hold. The hospital expects, and rightly insists, that he shall pay strict attention to these orders, since he is no longer an irresponsible student, but for the time being one of the cogs in the wheel on whose integrity the smooth running of the hospital depends. With growing knowledge comes growing responsibility, and he must show himself worthy of the trust reposed in him.

THE CHILDREN'S DEPARTMENT.

Physician-in-Charge, Dr. Cameron.
Chief Clinical Assistant, Dr. Ryle.

In-patient accommodation.—Dr. Cameron has under his care 12 cots, which are housed in Miriam, the surviving part of the Clinical Wards. On one day in the week, at present on Tuesdays at 12 noon, Dr. Cameron goes round the ward and gives clinical instruction.

Out-Patient Department.—Children under 7 years of age are seen in the Children's Department at Out-Patients on Mondays, Wednesdays, and Fridays from 9.30 until 1 o'clock. Dr. Cameron attends on Mondays and Fridays at 10 a.m., when clinical instruction is given.

The Salomons Centre for the care of the mothers and children of the Midwifery Charity is approaching completion. The times of attendance of Midwifery Registrar and of the Medical Officer will be arranged later.

NEUROLOGICAL DEPARTMENT.

There will be two Out-Patient Days, one of which (Wednesday) will be for ordinary cases, and the second (probably Friday) for the more complete investigation of selected cases. On the former day instruction will be given in the general methods of diagnosis and treatment; on the latter, instruction will be given in more special methods of investigation, such as lumbar puncture, examination of cerebro-spinal fluid, and administration of salvarsan to cases of syphilitic origin, and methods of re-education of impaired functions.

A clinical demonstration will be given, as in the past, on selected cases at 12 o'clock on Wednesdays.

Cases requiring more prolonged investigation and more special treatment will be taken into the beds attached to the Neurological Department.

It is hoped that an Out-Patient Clinic will be arranged every day in the week for soldiers suffering from war neuroses, where students will have an opportunity of acting as clerks, and learning the various forms of psycho-therapy required in the treatment of hysteria, psycho-asthenia, and other neuroses.

THE DERMATOLOGICAL DEPARTMENT.

Out-Patient Days.—Tuesday, 11 a.m.; Thursday, 9.30 a.m.

On Tuesdays all new cases, and ordinary old cases are seen. Children are seen in the morning from 11 a.m. to 1 p.m., adults from 1.30 p.m. onwards.

On Thursdays from 9.30 a.m. to 1 p.m. only cases of special interest, or those requiring careful supervision attend, but patients sent to hospital by doctors who require advice urgently, may also be seen on this day. Six beds in the medical wards have been allotted to the Physician-in-Charge of the Department, and they are reserved for the investigation of interesting cases, or for patients who require treatment in bed.

Instruction in the diagnosis and treatment of diseases of the skin is given in the Out-Patient Department, and clinical demonstrations on selected cases will be given from time to time.

THE AURAL AND LARYNGOLOGICAL DEPARTMENT.

The Aural and Laryngological Department is organised on the "unit" system; the patients seen in the Out-Patient Department are admitted to the special beds and return to the Out-Patient Department.

The Out-Patients attend on four days in the week (Tuesday and Thursday, Mr. Mollison; Wednesday and Friday, Mr. Layton). Dressers have every opportunity of becoming expert at the special technique of examination of the ear, nose and throat, and gain experience in diagnosis and treatment. Large numbers of school children are seen, and about 800 minor operations are performed a year; of these the great majority are for the removal of tonsils and adenoids. This most important operation may thus be learnt, since the dressers perform the operation under the supervision of the Surgeon or the Clinical Assistant.

Eighteen beds are now allotted to the department and the in-patient operations are performed on four days a week. Mr. Mollison and Mr. Layton "take-in" during alternate weeks, and emergencies are admitted to the department under the care of the "firm" on duty.

THE OPHTHALMIC DEPARTMENT.

The Ophthalmic Department of the Hospital is in charge of the two Ophthalmic Surgeons. They are helped by two Assistants, a House Surgeon and Dressers. The dressers are appointed four times a year for a period of three months, and assist the Surgeons at Out-Patients and at operations, and are responsible for the recording of the cases both in the wards and at Out-Patients. The Ophthalmic Department is an open field for any student to explore as far as he is willing and able, the amount of clinical work being sufficiently great for him to see all the more ordinary and common diseases of the eye in the space of three months. He is allowed to watch the Ophthalmic Surgeons perform any operations.

The student will soon find that he is quite unable to form any opinion of his own, on an ophthalmic case, until he has mastered the use of the ophthalmoscope and can readily and accurately decide what is the refraction of the eye, and if the "fundus oculi" is healthy and normal. The theory of retinoscopy can be taught and is simple; the practice, however, requires constant application by the student before he can hope to obtain any sort of facility in it. The difficulties are mainly initial ones, and any time and trouble expended in mastering them will well repay any man in after life when he has qualified and is in practice.

The Ophthalmic House Surgeoncy is one of the most important in the Hospital, as the Ophthalmic House Surgeon is not only in charge of the Ophthalmic beds, but also of Ear, Nose, Throat, and Orthopædic beds, so that his experience is wide and his responsibility great.

THE ORTHOPÆDIC DEPARTMENT.

The Orthopædic Department comprises a large out-patient clinic and ten beds devoted to patients suffering from deformity. Out-patients are seen on Monday and Wednesday afternoons, and in the Out-Patient Department the student will meet with every variety of deformity, congenital and acquired. Considerable facilities are afforded for experience in the relief and cure of all chronic diseases of bones, joints, muscles, etc. Instruction in the principles and most modern practice in the use of appliances, plaster technique, and the more useful forms of physio-therapy is given by Mr. Trethowan, the Orthopædic Surgeon, and Mr. Todd, the Orthopædic Registrar. Numerous operations of a minor nature are done, such as manipulations for stiff and painful joints, correction of mis-shapen and ricketty limbs, plastic correction of scoliosis, and plastic immobilisation of tuberculous joints.

The in-patient beds are devoted to the most serious operative cases, such as extensive tendon transplantations, correction of mal-united fractures, bone-grafting, the making of new joints, etc. Guy's is a pioneer in possessing an excellent workshop for the manufacture of every form of splint and appliance.

It is in the Orthopædic Department that the principles underlying the mechanical disabilities of the limbs and spine are emphasised and their explanation made clear, and the experience to be gained here is invaluable. The great utility of orthopædic surgery has become evident to very many during the war, and the extensive orthopædic administration now devoted to the care of pensioners will almost certainly merge into some big national scheme for the care of vast numbers of crippled children.

THE GENITO-URINARY DEPARTMENT.

Students have in this Department good opportunities of picking up knowledge which is likely to be of value to them in examinations, and also in actual practice. Out-Patients are seen on Wednesday and Saturday mornings, and Mr. Thompson operates usually one day a week, and also as opportunity offers.

The marked feature of last year was the large number of growths of the bladder which were seen, and in the majority of cases operated upon. It must be remembered that in many cases these are sent up far too late for operation to do much except in alleviating symptoms. The great disadvantage, which is attendant upon delay in adequate treatment, is the probability of septic cystitis and ascending nephritis rather than a rapid spread of the local disease. Hæmorrhage from a growth means ulceration, and ulceration means sepsis.

During the past year progress has been made in securing graphic records of bladder pressure, and it is hoped to continue this work during the next session. It is also hoped that very shortly the In-Patient side of this Department will be increased and that women may be treated in special beds.

THE MASSAGE DEPARTMENT.

The work done in the Massage Department should be of great interest to all medical students studying the after-treatment of medical and surgical cases. Very much can be learnt by following up the treatment of cases transferred from the different parts of the Hospital to this Department. Students should visit and listen to the clinics given by the Medical Staff or watch the treatments carried out by the masseuse. The Sister is always willing to explain or demonstrate a treatment at the request of a student. Over 200 patients receive daily treatment in the Out-Patient Department and some 50 In-Patients.

Times of Attendance.

The Lower Department from 10 to 11 a.m.—

Monday, Clinics by Mr. Westman.

Tuesday and Thursday, Clinics by Mr. Todd.

Wednesday, Clinics by Mr. Trethowan.

The work consists of the after-treatment of recent fractures, dislocations, stiff joints, paralysis, nerve injuries, rheumatoid arthritis, deformities, and many other diseases.

The Gymnasium at the Top of Hunt's House from 10.30 to 11.30 a.m.

Tuesday and Friday, Clinics by Dr. Hunt.

The work in this Department is wide and varied. Especially interesting is the treatment of heart cases by progressive muscular exercises and empyema cases by breathing, progressive muscular work and games. The number of scoliosis treated proves the satisfactory effect of the treatment, and can be watched on Monday, Tuesday, Thursday and Friday.

DENTAL SCHOOL.

The Dental Student is supplied at the Medical School Office with the Prospectus, Standing Orders, List of Instruments, Calendar, and Clubs' Union Book.

These pamphlets should be carefully read in order that acquaintance may be made with the general arrangements of the school and the scope of the work upon which the student will become engaged.

Notices regarding the time and place of Lectures are to be found posted up at the main entrance of the Dental Department.

Instruments having been purchased at a dental depôt, the student should satisfy himself that he has been supplied with all of those described in the hospital list.

First and second year students need only those instruments necessary for Prosthetic work, and are advised not to purchase instruments used during their clinical period of study (third and fourth years) until the commencement of the third year.

Among the various depôts at which instruments may be purchased are the following:—Claudius Ash, Sons & Co., Broad Street, Golden Square, W.C.; Dental Manufacturing Co., Alston House, Newman Street, W.; and Cottrell & Co., 15, Charlotte Street, W. 1.

First and second year students have a simple routine to follow. Their work is confined chiefly to Dental Prosthetics, but Chemistry and Physics and Dental Metallurgy are also studied and should be passed, the first two subjects during the first year the third during the second year.

The student will come into actual contact with Hospital patients during his second year, and he should always endeavour to be punctual in his appointments with them. There is nothing more irritating and annoying to a patient than to be kept waiting unnecessarily; it also delays to a very great extent the easy working of the Department. Further, the student should remember that the cultivation of a courteous and gentle manner towards his patients will become in the future probably the greatest asset in his private practice.

Third and fourth year students commence their clinical courses with probationary work upon the phantom head. This will occupy the time for about two months. This operative course, conducted by the staff demonstrators, is very comprehensive. It includes most of the conservative operations that the student will subsequently be called upon to perform upon patients, namely, gold and other fillings, crowns, inlays, and the treatment of devitalized and septic teeth. These operations upon the dummy form an excellent ground work in operative dentistry.

Thereafter the course of work consists in holding and diligently carrying out the work of the following appointments:—*Probationary Dressership in the Conservation Room; *Dressership in the Conservation Room; *Dressership in the Children's Department; Dressership in the Ordinary Extraction Room; Dressership in the Gas Extraction Room; Carnally Dressership; Clerk to Anæsthetist.

A student, apart from those holding the post of Assistant Dental House Surgeon or Clinical Assistant, and men up for Part II. of the Final Examination for the L.D.S., is not allowed to work in the Conservation Room unless he holds one of the appointments marked *.

Dental students will profit by following the practice of the Special Departments of the Hospital, *e.g.*, Eye, Throat, Ear. They will also have numerous opportunities of observing the more remote effects of dental disorders in the General Wards and Out-Patient Department.

Students in difficulties about their work and needing advice are invited to consult the Dean, the Resident Dental Officer, or any other member of the Staff, who will be pleased to do what they can to promote the interests of students.

Ed.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

ANNUAL INAUGURAL ADDRESS TO THE PUPILS' PHYSICAL SOCIETY.

We are happy to announce that after a lapse of five years one of the Hospital's oldest customs will shortly be renewed. Sir William Hale White has accepted the invitation of the Pupils' Physical Society to deliver the Annual Inaugural Address on 6th November.

It has been the custom of the Society for many years to commence the year's activities with such an address, but this, however, like many another time-honoured custom, had to go by the board during the war.

It may be well to mention here, for the benefit of those who have recently entered the wards, that all Clubs' Union subscribers are members of the Physical Society, the oldest Society of its kind, by the way, in London. It is hardly necessary to say that the success of the meeting is likely to be greatly enhanced if as many members as possible make it their business to attend.

ON Tuesday, October 28th, a general meeting was held in the Physiological Theatre to determine what was to be done with the £5,300 which had been collected by the War Memorial Committee. It was decided that £2,000 should be devoted to the erection of a permanent memorial in the Park, the nature of which should be decided by a leading firm of architects in London; that £1,000 should be set aside in order to assist the dependents of Guy's men fallen in the war; that £2,000 should endow scholarships, preferably for the sons of old Guy's men, the conditions of which should be decided by the Medical School (to which the balance of the £1,000 for dependents of Guy's men fallen in the war should be added); and that the remaining £300 should go to adorn the College Dining Room.

Previously a meeting of the War Memorial Committee had been held, and had appointed the following Executive to carry out the wishes of the general meeting:—

Mr. Cosmo Bonsor (Chairman).
Sir W. Hale White.
Sir Alfred Fripp.
Dr. Fawcett.
Dr. Spurrell.
Mr. Maggs.
The Dean of the Medical School.
The Hon. Sec. of the War Memorial Committee.
The President of the Residents.
The Editor of the GAZETTE.

We should like to take this opportunity of expressing our appreciation to Dr. Pembrey, the Hon. Sec. of the War Memorial Committee, of all the strenuous work he has done in connection with the collection of funds for the Memorial.

THE Guy's Biennial Festival took place on the evening of October 28th. As was hoped, a record number of Guy's men were in attendance. The whole evening proved most enjoyable, and although, to the regret of all, Dr. Shaw was unable to take the chair through illness, his place was admirably filled by Sir Arbuthnot Lane, and the evening was an unqualified success.

The success of the dinner was entirely due to the untiring energy of Mr. Steward, and we take this opportunity of tendering the most hearty thanks of all to him for a most enjoyable evening.

ON another page we print an appeal from the Guy's Hospital Trained Nurses' Institution. It is hoped that all old Guy's men will note this letter, and, if possible, employ Guy's Nurses in their private practices. We are sure that such a proceeding would redound not only to the good name of Guy's as a training school for nurses, but also to their own advantage.

IN these days of reconstruction, it is almost universally being attempted at Guy's to revive the old *esprit de corps* which has been so marked a feature of this Hospital. It is with great regret, therefore, that we hear reports from the Back Surgery which are not at all complimentary to those whose privilege it is to look after that section of the Hospital's work. In olden days, we believe, it was considered an affair of honour for the Dressers on duty to have the Back Surgery empty by 11 o'clock, and although the Hospital regulations require a Dresser to attend there at 9.30 a.m., it was rare for anyone to be later than 9 a.m. It is hoped that the present Dressers will make an effort to revive the old traditions of the "Back" if from no other motive than from one of sympathy towards the patients who attend there with such painful conditions as demand immediate attention.

OUR heartiest congratulations to the Rugby XV. on their magnificent display against Oxford University on the 22nd ult. Everyone about the Hospital has entertained great hopes for this year's XV., and so far events have fully justified them. May they have an equal amount of success next spring when they contest for the Inter-Hospital Cup!

Guy's Hospital War Memorial.

	£	s.	d.
Brought forward	4,955	2	10
Jones, J. Gaymer	2	2	0
Hubbard, Hon. Evelyn	21	0	0
Richards, Owen	1	1	0
Shick, Miss H. H.	1	1	0
Roper, Richard	1	1	0
Barber, H. W.	5	5	0
Brown, R. King	2	2	0
Saul, E. R.	1	1	0
Reed, T.	1	11	6
Richards, D. Oliver	5	5	0
Dobson, M. R.	3	3	0
Abdy Collins, H.	2	2	0
	£5,001	17	4

Change of Address.

H. A. A. Pargeter, 49, Grove Road, Wanstead, E. 11.

A. W. Sheen, M.S., F.R.C.S., 17, Gloucester Place, Portman Square, W. 1. (Tel. Mayfair 813).

F. N. Sidebotham, Newland House, Eynsham, Oxon.

Capt. D. H. A. Galbraith, M.C., R.A.M.C., M.O. 3rd Lahore Divisional Train, Egyptian Expeditionary Force.

H. Mather, 73, Rodney Street, Liverpool. (Tel. 947 Royal).

A. Sandison, M.B., B.S., 21, South Park Hill Road, South Croydon.

F. Morres, late Capt. R.A.M.C., L.C.C. Mental Hospital, Cane Hill, Coulsdon, Surrey.

Lieut.-Col. E. C. Hare, The Cottage, Amberley, Glos.

F. G. Cross, F.R.C.S., British Club, Las Palmas, Grand Canary.

Salpingitis.

CLINICAL LECTURE BY H. CHAPPLE, M.C., F.R.C.S.

GENTLEMEN,—We have had several cases of salpingitis to deal with recently in the Out-Patient Department and Queen Ward, so I thought I would make them the subject of my clinical lecture to-day, as I wish particularly to discuss the treatment of this condition with you.

Salpingitis is a common condition, and I have here the history sheets of a number of cases, which can be roughly divided from a clinical standpoint into two groups, the acute and the chronic, though the former group tends to merge into the latter, and in a large proportion of the latter you will notice it has not been possible to elicit any particularly acute history at the time of onset of the trouble.

First of all let us consider the cases of acute salpingitis, and case No. 4 may be taken as a typical one. L. F., æt. 24, a recently married woman, was admitted complaining of severe pain in the lower abdomen of three days' duration. She had vomited several times during the attack, and stated that her period had come on about a fortnight early. Her bowel had acted, but not satisfactorily. Her face was flushed and her tongue dry and furred. Her temperature on admission was 101·8°, and her pulse 112. She was observed to have a certain amount of distension of the lower abdomen, and, although she resented palpation of the lower part of her abdomen, it was possible to make out a definite amount of rigidity. On vaginal examination there was a marked leucorrhœa and a blood-stained discharge, which had not the characteristics of the normal menstrual period. The fornices were very tender, especially the left one. No definite pelvic mass could be made out, but the Pouch of Douglas felt full. Microscopic examination of the cervical discharge showed no gonococci in the film. She was clearly then suffering from an acute pelvic peritonitis, and the question arose as to what was the cause of the condition.

There are three conditions in which you are likely to encounter symptoms of this kind, viz.:

1. Acute Salpingitis.
2. Acute Appendicitis.
3. Extra-uterine Gestation.

And the differential diagnosis is of importance, as the second and third demand immediate surgery, whereas the first does not, except under certain definite conditions.

In making the diagnosis you will have to rely on the following points :—

1. *The History.*—Acute salpingitis is most likely to follow on an abortion or labour or some uterine instrumentation or an attack of gonorrhœa. If there is a definite history of gonorrhœa and the organisms are detected in a smear from the urethra or cervix, it is very valuable information; at the same time I want you to remember that an attack of gonorrhœa in women is frequently not attended with marked acute symptoms as in the male, but is often comparatively slight and may be passed almost unnoticed. The detection, then, of gonococci in the urethral or cervical discharge will, of course, be definite evidence, but do not forget that they are not always easily detected after the lapse of a little time. In acute appendicitis the onset is usually sudden, and the first symptom is nearly always abdominal pain.

In extra-uterine gestation there are three histories : There may be amenorrhœa of some six or eight weeks' duration, but this is not by any means always the case. Rupture of the sac may occur before the time of the next menstrual period, and there was a case in Queen of only ten days' duration, or the first sign may be a period of unusual length accompanied by severe pain.

2. *Pain.*—The pain of an acute salpingitis is often very severe, it is referred to the lower abdomen, and is usually bilateral in position. Too much stress should not be laid, however, on the bilateral nature of it, as in several of these cases the symptoms were markedly unilateral. Some of you will remember the patient in No. 7 bed who permitted me to feel the right side of her abdomen without protest, but when I tried to examine her left side she cried out with pain. When I opened her abdomen, both tubes were equally affected as far as naked eye appearances went.

The pain of an appendix may be more or less general at first or referred to the region of the umbilicus, but it usually settles down fairly soon to the region of the appendix and becomes more or less localised to the neighbourhood of that structure.

The pain of an ectopic may also be very severe. I want to again draw your attention

to the fact that in this condition seven cases out of ten result in the formation of a tubal mole, and this may not rupture or cause profuse intra-abdominal bleeding for several days, so that the pain is intermittent in character and occurs when there is a leakage of blood into the pelvic peritoneum. Of course, if the extra-uterine pregnancy ends by rupturing into the abdomen, the pain is severe and more continuous. There is one striking characteristic of such cases that I have often noticed—the abdomen contains free blood and is very tender, but not rigid.

3. *Uterine Hæmorrhage.*—In acute salpingitis if the uterine body is also markedly affected, irregular bleeding will take place from the uterus. In appendicitis there will be no such irregularity, whereas in an ectopic when the pregnancy is interfered with, the decidua is cast off from the uterus and an almost characteristic dark "prune juice" discharge takes place, and there may be a cast of the uterine cavity thrown off either in one large piece or a number of smaller fragments. In the cases that end by early primary rupture there will be no uterine hæmorrhage until the decidua of the uterus is cast off, and this may be two or three days after the rupture of the sac.

4. *Vaginal Examination.*—If you are investigating a case of acute salpingitis at the onset there will be no definite pelvic lump, but gentle digital examination of the posterior fornix will produce a considerable amount of pain, especially if the uterus be moved and the tubes handled. A little later, as the tubes and ovaries get drawn down into the Pouch of Douglas, or an exudate is poured out into that space, a definite, very tender mass will be felt.

In appendicitis unless the appendix is low down in the posterior pouch, it will be possible to manipulate the uterus apart from the affected organ. Again, in an ectopic, if you are dealing with a tubal mole, a definite mass will be felt. On the other hand, in the early stage of a ruptured ectopic there will be no mass, but a collection of blood will be present and will be detected vaginally according to the degree of clotting present, either as a fluid filling the Pouch of Douglas or as a definite hæmatocele.

5. *Pulse.*—The pulse rate in acute salpingitis should correspond with the temperature. A rising pulse rate is a definite indication for surgical treatment, as it is one of the signs of a spreading peritonitis or a severe type of infection.

In appendicitis a rising pulse rate is a definite danger signal that things are going wrong. In an extra-uterine gestation a rising pulse is an indication of intra-abdominal bleeding and demands immediate laparotomy. Let me emphasise once again the importance in all three conditions of dealing with the trouble before the pulse rate has risen to any great extent, or you will be in grave danger of delaying too long.

6. *Incision through the Posterior Fornix into the Pouch of Douglas.*—This will reveal free pus in an acute salpingitis or appendix situated low in the pelvis if an exudate has been passed out, and blood in the case of an ectopic.

The treatment of acute salpingitis.—I have gone into some detail with regard to the diagnosis of the condition, as the best treatment of acute salpingitis is not immediate surgery except under three conditions :—

1. If the diagnosis is doubtful and cannot be definitely made.

2. If there is any evidence of a spreading peritonitis or if the patient is getting worse.

3. If there is a collection of pus in the Pouch of Douglas.

My reasons for this statement are these :—

(1.) Acute salpingitis is often a recoverable condition and is not, as a rule, a fatal one. This is especially true of the gonorrhœal variety, which tends to localise to the pelvis and does not often spread to a general peritonitis. I have on three occasions opened the abdomen in young women and seen pus exuding from both Fallopian tubes. As the patients were young and very anxious to have children, I did not remove the tubes, but merely drained the pelvis and closed the abdomen. Each of these three patients has since had children.

(2.) The disease tends to localise itself, and if you delay your surgery till the process has settled down, you will have a definite lesion to operate on, and not find yourself in the awkward position of wondering how much or how little you should remove. It is vitally important in young women to remove as little of the pelvic organs as possible. If you operate early you will remove much structure which there was no need to take away.

(3.) The risk of your operation is not nearly so great, and the chance of wound infection and

subsequent hernia, etc., is much diminished, as the virulence of the organisms very rapidly becomes less. In old cases the tube contents are very frequently sterile.

If you are sure of the diagnosis and the pulse rate remains in proportion to the temperature, and there is no evidence of a spreading peritonitis or collection in the Pouch of Douglas, the patient is sat up in bed in the Fowler position and fed only on fluids. The pain is kept under control by morphia and hot applications or ice-cold applications are made to the lower abdomen and pelvis according to which are found to give the greater relief. The bowels are regulated by saline purgatives. If the salpingitis is an accompaniment of an acute gonorrhœa, nothing can be done during the acute stage in the way of local applications as manipulation of the pelvic organs is not only very painful, but very unwise. The discharge is removed either by swabbing the vulva gently with a weak biniodide solution or ordinary normal saline solution. Remembering that urethritis is a very common accompaniment, the patient is given large quantities of fluid to drink and hexamine given to prevent a spread into the bladder. As the acute symptoms begin to subside, more active local treatment is called for, and suitable applications are made to the cervix and urethra.

Under this strict regime, in about ten days the temperature will have settled down to the normal, as a rule, and the pain be much less, or have disappeared. Vaginal examination will now reveal a definite pelvic mass. I now make use of pelvic heat baths at a considerable temperature for about half an hour daily. In the absence of pain and temperature the patient may be allowed up, but a rise of temperature or increase of pain will be a definite indication to go back to bed again. When the treatment has been carried on for some three or four weeks the pain is usually very considerably relieved and has often quite gone, and the pelvic mass will now be found in a number of cases to have practically cleared up. A proportion of cases will be found to require no further treatment. On the other hand, if it is still found necessary to operate, and the majority of cases will require further treatment, it can now readily and safely be done.

Now as regards chronic salpingitis.—Case No. 9 is a most typical one and presents nearly all the features of this condition. N. T., a woman of 34, had been married for seven years, but had had no children. She complained of abdominal pain of an intermittent nature which was worse for four or five days preceding her menstrual periods. She had lately had irregular hæmorrhage from the uterus and complained of dyspareunia. Her bowels had acted with greater difficulty lately. She gave no history of any acute infection, but was chiefly concerned about the pain and sterility. Vaginal examination revealed a definite tender mass posterior to the uterus which was more or less fixed, and any attempt at movement produced pain. A close questioning elicited that she had had three attacks of illness in the last five years in which she had had a temperature, but there was no obvious cause discovered.

This was obviously a case of chronic salpingitis, and a course of pelvic heat baths was given. She did not gain great benefit from them, and the temperature having been normal for four weeks, it was decided to operate.

In cases of this kind the question naturally arises as to what operation is wisest?

I cannot give you a detailed description of a definite operation that is suitable for all cases, as on opening the abdomen you will find the various pelvic organs are affected in varying degrees. So I can help you most by giving you principles that will guide you when you come to deal with individual cases. Your aim should always be to remove only such structures as are hopelessly diseased.

Firstly, then, make up your mind you will be as conservative as possible, being especially guided by the "temperament" of your patient. By temperament, I mean the strength of her desire for intercourse and for maternity. They are much more important guides than her social status or anything else. Remember that the ovaries are the analogues of the testicles, and there should be a very, very strong reason if they are to be removed. Removal of the ovaries produces different effects in different women. In a large number of cases very serious symptoms have followed. I have twice seen these effects proceed to definite insanity.

Secondly, remember that efficiency is a more important factor in operating than speed. By all means be as fast as you can, but do not omit to finish your operation in order to reduce the time you spend on it. This is most important in conservative operations on the pelvis. Your operation is only one very important step

in the treatment of your patient. For instance, remember that a common cause of failure to relieve the pain is the formation of adhesions, and this is most important if a loop of small intestine becomes adherent to the raw surface. Though this accident cannot be absolutely avoided, the chance can be reduced to a minimum by covering all the raw surfaces carefully with peritoneum, and when you have finished, instead of jumbling the intestines back into the abdominal cavity in a heap, take especial care to put the pelvic colon in its right position in the pelvis, so that if anything is going to be fixed afterwards, it is the pelvic colon. That will not cause so much trouble as will adhesion of the small intestine. Also, finish up your operation by suspending the uterus in the front of the pelvis. We frequently see patients in whom the uterus has been left retroverted and become attached posteriorly. Then followed the usual symptoms—dyspareunia, congestion, dysmenorrhœa, and back-ache, all of which could have been avoided if time had been taken at the operation to sling the uterus forward and keep it out of the way of harm.

One other point is that it is better to cut out your affected tubes completely. It is common to see a clamp placed on each end of the affected Fallopian tube and a portion of it which is attached to the uterus left behind. I think it is much better to cut that bit out of the intra-uterine part of the tube and over-sew the area, then fasten the round ligament on to the stump, and so keep it supported in the pelvis.

Prolapse after hysterectomy is not a rare occurrence, and can usually be avoided by taking a little time and fastening the round ligament to the stump of the uterus which you have left.

A fourth point is, take care of the blood supply to the organs. I am telling you to be conservative; but it is useless to leave the ovaries if you clamp off the blood supply to them; you might just as well remove them as starve them of blood. The ovarian vessels come in along the infundibulo-pelvic ligament, and the branch from the uterine artery can be seen running along the upper part of the broad ligament, and there is generally plenty of room to keep clear of that branch if you take the trouble to dissect the tube out.

Thus my advice is, always do your utmost to save the ovaries, whatever the age of the woman. It seems almost impossible to eradicate the idea that the ovaries play an almost negligible part in the female, and from the description of certain surgical procedures that are seriously suggested one might almost gather that it was not only desirable, but clever to remove them. No one would dream of taking both testicles out of a man without a very urgent reason, yet ovaries have often been, and are still, removed from women on very small grounds. The effect may not be so dramatic, but it is often very disastrous. If one ovary must be removed, try your best to leave the other one. That can often be done if the operator gives himself time to dissect the pyosalpinx off the ovary. If you leave one, the worst thing which can happen to that woman is that you may have to operate again later on. To remove both ovaries unnecessarily is a tragedy. If you leave one ovary, menstruation may be irregular, it may gradually become less, but there is always the possibility that pregnancy may follow; you have already seen a number of women who have become pregnant though they possess only one ovary. That, in a woman of the temperament we have been speaking of, is a most important thing. If you must remove both ovaries, take the uterus out as well, for it is a useless organ without an ovary, and it may be full of potential harm.

If you decide to remove the uterus, and you have your choice, do a simple supra-vaginal hysterectomy. It is always best, having in view the chance of future prolapse, to leave a portion of the cervix in the pelvic floor, and then fix the round ligaments to the stump of the cervix, and so hold the whole floor up. By that means you will save your patients a great deal of subsequent discomfort and trouble, or at least a great proportion of them.

Of course, when you are operating in this part of the body you will always see that the appendix is not involved in the pelvic inflammatory mass. If you find that the appendix is affected, you will remove it.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

Dear Sir,

As many Guy's men have returned and others will be returning to their old fields of labour, and doubtless making inquiries about the various Departments of the Hospital, some information regarding the Guy's Hospital Trained Nurses' Institution may be acceptable.

In its world-wide effects the war included the Institution and dealt very drastically with the efficient routine and considerable financial success of thirty years.

Difficulties have been many. Entirely owing to the demands of war, the nursing staff was reduced from 120 to 40 and less. There is no monetary connection with the Hospital, and I may leave your readers' imagination to deal with the results of falling receipts and rising prices.

For the work of the Nurses, however, during the war years, I can claim with confidence your readers' pride and appreciation. From August, 1914, onwards, all Nurses who wished to do so were granted leave of absence to enter the various military nursing services at home and abroad, Queen Mary's Royal Naval Hospital, Southend-on-Sea, Auxiliary and Private Hospitals.

Their records include many honours. Distinction cannot come to all, but from the reports of patients and Guy's men we know also of untold skill and kindness received by the sick and wounded at the hands of our Nurses whether "decorated" or not.

The services of those Nurses who elected to continue their work on the Private Staff have been of great benefit to the civil population and their medical men. Much endurance has been required to meet the strain occasioned by the Influenza epidemic, the coal shortage, and the entire absence of domestic help in most houses.

As is well known, the "Institution" and the "District" are worked together, and are complementary to each other, so I need not remind Guy's men of the "Nurses' side" of the Guy's Extern Maternity Charity. It has played a great part in the homes and buildings of Southwark for 30 years from the humanitarian point of view, and as a training school has enabled some hundreds of Guy's Nurses to obtain their Midwifery Certificate in connection with their own Hospital.

Certain improvements in organisation have taken place. The Midwifery Sister has a qualified Assistant to relieve her alternate nights and week-ends. In 1916 an unofficial Babies' Clinic was started here and proved very popular.

Now that there are five Maternity and Child Welfare Centres in Southwark under the control of the Medical Officer of Health, ours is no longer needed, and when our Nurses say "good-bye" to a mother on the tenth day, they give her a card for the nearest Centre. Eventually all the Centres in Bermondsey and Southwark will be linked up with the Salomons Centre, but that is another story and promises to be a very fine one.

The most needed reform has been the large amount of pre-natal visiting undertaken by the Nurses. We have aimed at the ideal, which is shortly to be an accomplished fact under the new maternity scheme, that no woman shall be attended under the Guy's Hospital Extern Maternity Charity who has not been sympathetically visited in her own home, and had the opportunity to obtain under convenient conditions any medical advice and treatment she may require. The Hospital will assume responsibility for her well-being and that of her unborn child from the moment of granting her "Card," not as heretofore from the arrival of the Nurse or Extern, as entire strangers to the patient, her physical condition and surroundings, when sent for at the time of labour.

During the war it was not an easy matter to keep the District going, as the newly-certificated Nurses on leaving the Hospital, naturally entered the military nursing services, instead of coming on here as Pupil Midwives. Those are now past trials, and it is to the present that I should like to draw the attention of Guy's men. The Staff is rapidly increasing and there are good Nurses available for Medical, Surgical, and Infectious cases, and a number who specialise in Midwifery.

Our Fees are identical with those of other Nursing Establishments, and outfits for surgical operations can be sent with the Nurse.

I shall at all times be glad to give further information, and to meet special wishes.

Yours truly,

F. A. SHELDON.

Lady Superintendent,
Guy's Hospital Trained Nurses' Institution,
14, St. Thomas's Street, S.E. 1.
1st November, 1919.

DEAR SIR, —Since the commencement of this term there has been a very great lack of courtesy and good manners shown at the majority of the lectures which are attended by third and fourth year Dental Students. At certain of these, there is one continuous series of interruptions of all kinds, interruptions both childish and unmannerly, so that I for one, and a number of others have stated the same thing, can often not hear what the lecturer is saying. Everyone admits that these lectures, both from the point of view of subject-matter and delivery, are among the finest one could wish for.

Surely we need not expect such childish behaviour, such a lack of manners as these interruptions, from grown-up men at a great hospital such as ours. I don't know whether the fault lies with "freshmen" in their exuberance of spirit or with older students who come to Guy's to waste their time, but I for one am not at all anxious to have my time wasted in this manner. There is too much to be learnt.

I must apologise for troubling you with this matter, but I know, from what I hear all round me, that I speak for a large section of dental students, Thanking you, I remain, yours faithfully,

A DENTAL STUDENT.

Dental Dept.,
Guy's Hospital,
London, S.E. 1.
Oct. 25th, 1919.

DEAR SIR,—May I through your columns express my very sincere thanks to the students in the Dissecting Room who presented me with such a delightful gift on the occasion of my marriage.

I have not been able to thank them all individually, but I should like to take this opportunity of telling them how greatly my wife and I appreciate their good wishes and their beautiful gift.—Yours sincerely,

E. G. SLESINGER.

The Olympic Games of 1920

DEAR SIR,—I feel that no apology is needed for taking up space in the "Guy's Hospital Gazette" on behalf of the above subject. It is not generally known that the British Olympic Council has promised on behalf of the Nation to support the 1920 "Games," which are to be held at Antwerp next September. This they were bound to do, seeing that other countries, which have suffered through the war more than ourselves, announced their intention of competing. But, the promise given, it is up to the sportsmen of the country to see that we are well represented. And they must not expect much assistance. About next August the Press will begin to boom the "Games," and the man-in-the-street will begin to ask what they are, and the correspondence columns of the morning papers will be filled with agonised appeals to athletes to come forward and save the situation. And it will all be just 10 months too late. If our prestige as the leading athletic nation is to be maintained, now is the time for men to find out if they are likely to make champions in track and field events. And anyone at all may be that. The winner of this year's Marathon had never put on a running shoe until he joined the army, and there must be many a man going about who would become as good an athlete as he is. Other countries are starting their preparations for the "Games" right away, and the Governments of France and Sweden—and probably others—have voted large sums of money to their Athletic Organisations. But as long as Englishmen know when the "Games" are to take place and that they are expected to prepare for them with little or no encouragement, we shall be able to hold our own, and perhaps even come out Victors next September.

In conclusion, I should like to say that, should anyone feel inclined to act on the above suggestion and take up running, either on the track or across country, I shall be very pleased to give him any assistance that I can, including the training facilities of my club, the "South London Harriers."—I am, Yours sincerely,

L. G. HOUSDEN.

Guy's Hospital, S.E. 1.
16th October, 1919.

Pass List.

Conjoint Board.

FIRST EXAMINATION.
Sept., 1919.

*W. F. Payne	‡R. A. Grant
*†T. Woolridge	‡O. F. A. Krause
*†J. L. Faul	‡R. C. May
*E. Sorabjee	‡D. W. C. Northfield
*†L. B. Helder	‡O. L. Truscott
†A. B. Davies	‡C. H. C. White
*†S. A. Leader	‡D. S. Todd-White
*†L. E. Owen	‡F. Woodford
*†C. E. Gallagher	*M. M. El Mishad
†‡G. T. Hankey	†H. Evans
†H. C. Lee	*H. MacLachlan

*Chemistry. †Physics. ‡Biology.

Part IV.—PHARMACY.

B. M. Tonkin. T. W. Turner.

SECOND EXAMINATION.
ANATOMY AND PHYSIOLOGY.
Sept., 1919.

M. A. El Biblawi.

University of London.

FIRST EXAMINATION FOR MEDICAL DEGREES.
Sept., 1919.

John Evans. S. C. Worseldine.
G. H. Pitt.

Royal College of Surgeons.

L.D.S.—Preliminary Science.

Sept., 1919.

S. E. Lewis	R. C. Andrews
L. S. Carter	F. A. Meyer
A. S. T. Garland	C. A. Wakeford
†C. D. Farris	†H. J. Walters
†G. G. T. Haynes	†A. L. Hyslop
†G. B. Kempster	L. W. Elmer
E. J. Joels	†S. Levinson
P. J. Walters	*O. D'E. Morris
A. S. Lundsler	*I. Broude
B. J. M. Kayter	*A. B. Dancel
J. I. de Villiers	†D. J. Stofberg
W. J. Olivier	†F. W. van der Hoven
C. M. A. Pauw	

*Chemistry only. †Physics only.

L.D.S.—1st Professional,

Mechanical Dentistry and Dental Metallurgy.

September, 1919.

*H. R. Banks	*J. A. Krige
G. R. D. Bradfield	H. A. F. Leipoldt
M. Braun	A. L. Mackay
M. F. Braun	S. P. Meacock
*T. E. Brevetor	O. D. Morris
*I. Broude	E. H. Muir-Smith
H. G. R. Canning	H. S. Murray
H. C. Churchill	J. H. D. Myatt
P. N. C. Conway-Jones	*W. J. Olivier
H. A. Coysh	A. T. Partridge
*A. B. Dancel	†C. T. Pomeroy
†J. L. de Kock	E. M. Power
†M. D. Desci	†G. E. Price
*J. I. de Villiers	H. K. Price
D. P. G. Dickens	*W. E. Silver
†P. Domb	S. W. Southwood
F. J. Downing	G. M. Stuart
†J. J. du Toit	H. C. Tweney
D. C. Eglinton	†R. van Geuns
†C. H. Edney	H. van Zyl
*L. F. Fouraker	H. R. Ward
*C. Glassington	*J. W. E. Warren
*M. B. Goolding	*N. B. Wells
*A. W. Greenwood	T. D. Wille
*G. W. Griffith	P. H. Williams
†A. Havengo	†G. S. W. Wills
†A. H. B. Heeson	W. H. Willis
*R. J. Hooker	†T. L. Winn
C. F. Hudson	C. B. Wood
A. L. Hyslop	B. C. Woodroffe
G. K. Jennings	*F. Woodford
*C. F. A. Krause	*F. A. J. Zettel

* Mechanical Dentistry † Dental Metallurgy

Leaves from a Medical Note Book

(1914—1918).

VI. Pneumococcal Meningitis.

Primary pneumococcal meningitis, that is to say, pneumococcal meningitis not secondary to a lobar pneumonia or other local infection, is generally regarded as presenting clinical features so similar to meningococcal meningitis as to be usually undistinguishable from that disease.

Obviously an absolute diagnosis requires the demonstration of the organism in the cerebro-spinal fluid, but there are, nevertheless, manifestations which justify confidence in a provisional clinical diagnosis. The most important of these is the rapid respiration rate which appears to be a constant feature in all pneumococcal infections, whether the lungs be involved or not.

The following case is an example—

A wounded German prisoner of war was admitted to a Casualty Clearing Station during the Passchendael battle, with a slight superficial wound of the chest-wall, requiring no surgical interference. On the next day he complained of feeling unwell, but owing to linguistic difficulties his symptoms were not accurately ascertained. His breathing was very fast, but repeated examination of the wound and chest revealed no signs of any intrathoracic lesion. Later he complained definitely of headache, and showed commencing neck rigidity. On previous experience the association of headache, stiff-neck, and polypnœa at once suggested the likelihood of pneumococcal meningitis. Lumbar puncture gave turbid fluid, and a specimen sent to the laboratory labelled "c.s. fluid . ? pneumococci," received a confirmatory report. The patient died the next day.

Another point noted by the writer, which has also been mentioned by other observers, is the colour of the pus. The purulent cerebro-spinal fluid seems to show a peculiar greenish tinge in pneumococcal meningitis.

Slight disturbances of the respiration rate may, of course, be noted in meningococcal meningitis, but in the pneumococcal variety the disturbance is an early and obvious feature.

(To be continued).

Appointments.

Medical School Appointments

1st October, 1919—15th January, 1920.

Probationary Clinical Appointment.—Messrs. J. K. Milward, A. T. Rogers, C. Shepherd, A. H. Douthwaite, M. A. El-Biblawi, H. B. Flooks, D. Davies, T. J. Lane.

Clerks to Medical Unit.—

(Second three months).—The Clinical Assistants (Dr. Fawcett and Dr. Cameron); Messrs. K. J. H. Davies, G. W. Elkington, J. B. Gregor, R. J. Hodgkinson, O. T. Maclaren, H. W. Taylor (Dr. Beddard and Dr. Hunt); S. Annecke, M. T. A. Elnakeeb, I. B. McCann, L. K. Watson, L. R. A. Wells (Dr. French and Dr. Poulton); F. Bekker, F. L. Rayner, E. H. Richards, M. E. Shaw, A. H. Shelswell (Dr. Hurst and Dr. Mutch).

Dressers to Surgical Unit (first three months).—Messrs. G. C. W. Curson, B. Kessel (Sir Alfred Fripp and Mr. Turner); G. E. W. Felce, C. M. Short, W. H. Summerskill (Mr. Steward and Mr. Hughes); M. T. Ahmed, A. E. Strawbaun, H. O. Eksteen (Mr. Fagge and Mr. Davies-Colley); E. Hardy, H. W. Harvey (Mr. Rowlands and Mr. Bromley).

(Second three months).—A. McKenzie, A. Mikhail, J. N. Alexander (Sir Alfred Fripp and Mr. Turner); J. H. Burn, I. W. Arnovitch (Mr. Steward and Mr. Hughes); M. Hall, J. T. Jones (Mr. Fagge and Mr. Davies-Colley); P. L. Richardson, R. E. Williams (Mr. Rowlands and Mr. Bromley).

Obstetric Dressers and Externs.—Messrs. *D. Maximos (Nov. and Dec.), J. J. F. Rooney, J. H. Sullaiman, E. F. Wilson (Mr. Bellingham-Smith); P. Couacaud, F. W. Crook, W. Remington, R. M. Patterson, I. Rosenberg (Mr. Chapple).

*Not Extern.

Assistants to the Pathologists to the Hospital.—Messrs. F. W. Crook and D. J. O'Meara.

Student Assistants in the Bacteriological Department.—Messrs. S. Cohen, K. J. H. Davies and M. E. Shaw.

Student Demonstrators of Anatomy.—Messrs. B. L. Laver and F. W. Widgery.

Assistant Surgeon's Clerk.—Mr. H. V. Croucher (Mr. Hughes).

Clinical Assistants.—Messrs. J. V. C. Braithwaite, W. G. Hay, G. P. Lindsay, W. W. Payne, S. Rose and W. S. Russell Thomas.

Appointments in Special Departments:—

Clerks in Department for Children—

A. *With Dermatology.*—Messrs. W. D. Doherty, C. I. C. Gill, M. Maizels and J. E. Wright.

B. *With Neurology.*—Messrs. E. E. D. Gray and E. T. Lloyd.

Clerks or Dressers in the Departments for—

Ophthalmology.—Mr. M. Sidky (Mr. Eason); Mr. H. A. Crowther (Mr. Ormond).

Dermatology.—Messrs. W. D. Doherty, C. I. C. Gill, M. Maizels, G. H. Oriel, C. M. Probert and J. E. Wright.

Throats (Mr. Mollison).—Messrs. W. Mark Brown, B. M. Tonkin and D. J. O'Meara.

Orthopædics.—Messrs. W. Mark Brown, B. M. Tonkin and D. J. O'Meara.

Neurology.—Messrs. E. E. D. Gray, E. T. Lloyd, G. H. Oriel, C. M. Probert and M. Sidky.

Genito-Urinary.—Messrs. †D. J. O'Meara, G. H. Oriel, †B. M. Tonkin, †W. M. Brown and J. Totton.

†One month only.

Civil.

C. E. Hicks to be Medical Officer of Health for Huntingdon.

F. Morres has resumed duties as 2nd Assistant Medical Officer, L.C.C. Mental Hospital, Cane Hill, Coulsdon, Surrey.

University of London.

Regulations for

The William Julius Mickle Fellowship.

The William Julius Mickle Fellowship was founded by William Julius Mickle, M.D., in honour of his great-grandfather, William Julius Mickle, the poet.

1. The Fellowship, of the value of at least £200, is awarded annually by the Senate to the man or woman who, being resident in London and a graduate of the University, has in the opinion of the Senate done most to advance medical art or science within the preceding five years, and has therein shown conspicuous merit.

2. Applications for the award will be invited through the Public Press, and shall be forwarded to the Principal Officer so as to reach him not later than 15th November, 1919; and the Fellowship will normally be paid not earlier than 1st January following. The Fellowship may in exceptional circumstances be awarded to a person who is not an applicant.

3. All applications for the Fellowship shall be made in writing, shall include (*a*) the names and addresses of not more than two persons to whom reference may be made; (*b*) a statement as to the period of the candidate's residence in London; and (*c*) full information with regard to the manner in which the candidate claims to have advanced medical art or science within the preceding five years.

4. Any work not already published submitted by an applicant in support of his candidature must be typewritten or printed, and six copies must be supplied.

5. The Fellowship will be awarded by the Senate after report from the Committee of Medical Members of the Senate who may appoint such assessors as they consider necessaryi to assist them in adjudicating on the award of the Fellowship.

6. Any applicant may be required to attend before a meeting of the Committee (or Assessors appointed by them) and to answer any questions connected with his candidature.

7. The Fellowship will only be awarded if a candidate of ocnspicuous or sufficient merit present himself.

8. If the Fellowship is not awarded either for the reason stated in paragraph 7 or for any other reason, then the net income for that year of the principal sum or capital fund of "The William Julius Mickle Fellowship" shall be added to that principal sum and be invested so as to form an addition to and augment the principal sum of the said Fellowship.

P. J. HARTOG,

July 23rd, 1919. *Academic Registrar.*

Football.

OLD ALLEYNIANS v. GUY'S.

At Dulwich, on Saturday, October 18th, a good number of Guy's supporters attended to see the Hospital again victorious. In no season for years can one recall such enthusiasm in the Hospital team, and it is indeed a good sign of the real Guy's spirit to find the representative XV. so heartily supported.

It was a match well worth seeing, though a little scrappy at first. Davies was a little uncertain; playing in strange company doubtless did not help him, but once he settled down he showed great form.

J. Krige, in the outside left position, was the first to score, and he cross-kicked for Reitz to gather for the second try. This place kick, quite an easy one, was strangely missed. Guy's still pressed, though it should in fairness be stated the Old Boys stretched our attack all they could. Aspinwall made a great dash, and there were constant attempts at try-getting, but we were kept out until Steyn kicked a very fine drop goal. Before the half whistle sounded some good passing right along the line sent J. Krige over with a try, which again went unconverted. Thirteen points to nil.

The Hospital restarted, and before many minutes had elapsed Aspinwall and Shellswell were both scorers. Doherty, with great judgment, put across for the last-named to get over. Van Schalwyck converted both these tries. Seldom have either of these two try-getters played so well. The last four tries went to Steyn's account. As far as one could see, his display was perfect. One try Reitz put on the extra points to.

Millett, returning to his old place, showed good form for one so short of training. All the rest of the team played well except perhaps one or two who had an off day. But taken as a whole, the XV. will make Oxford go all the way next Wednesday. Van Schalwyck gave his passes without in the least attempting to clear a single individual; sometimes this may pay, but surely the occasion is very rare. Davies and P. Krige were both thrown heavily and complained of damaged shoulders; one hopes their injuries are not severe. Bekker was great at base scrum; perhaps one may suggest that boring through the scrum only comes off very, very seldom. It is doubtful if it pays. With such a line behind him, they are the most dependable source of points. One does not suggest that the obvious is the better form of attack; but the present Guy's team are undoubtedly at their best with a "loose" ball.

Guys, 3 goals, 1 drop goal, 6 tries = 37.
Old Alleynians nil = 0.

TEAM.—H. Millett, G. L. Steyn, G. H. Davies, P. Krige, J. Krige, T. Bekker, G. Van Schalwyck, W. D. Doherty, F. W. Reitz, A. H. Shellswell, G. R. Aspinwall, A. Marais, E. Neser, L. K. Watson, G. Zondagh.

GUY'S v. OXFORD UNIVERSITY.

It was a bit of a blow to find P. Krige unable to play in this match, especially as one wanted to see the brothers on the left wing fully extended. The damaged shoulder of Saturday's match at Dulwich was the cause of Krige's absence. Full of hope and confidence the team, nevertheless, journeyed to Oxford on the 22nd and they returned full of glory and satisfaction. One quite admits it is early in the season for a University XV., but there are so many for and againsts, it is good enough to know we won by 24 points to 3.

Woodruffe took the outside position on the left, J. Krige played at centre. Woodruffe had not the good fortune to score, but he tried jolly hard; a little more pace would be a great advantage. Steyn opened the scoring for Guy's after the three-quarters had tried some passing. Guy's forwards were playing well, better than any previous match, and the ball was kept lively, a great asset if you are in scoring mood. A well-accepted pass by Steyn, a punt across, and ever-ready Marais went over for a try, Millett scoring an easy goal. Neser of Oxford showed the way for the Varsity, but they never really got going, and later this excellent forward was pulled out of the scrum to strengthen the defence. Woodruffe had a good run and then once again Steyn ably assisted by the back division, gained a try, and before half-time Doherty scored another, which was a little fortunate, the captain going over after a mix up on the line. Millett kicked a grand goal from this try, and half-time found us 16 to nil on the right side.

Havard of Oxford showed splendid form, dribbling at a great pace. He and Neser were the pick of the Oxford pack. Millett stopped these attacks, but Skeet, lying handy, managed to secure and gain what proved to be Oxford's only try. Davies sent Steyn in after this, Millett goaling splendidly. Then the Hospital had to defend for a time; Skeet took some watching. Our defence, however, stood the test, and after a time the ball was worked to mid-field. Play was now of a more even character till the right wing got possession, the ball eventually reaching Steyn, who transferred at the right moment to Davies, and the Llanelly man went over for a try too difficult for Millett to improve on. The final score read—Guy's, 3 goals 3tries, 24 points; Oxford University, 1 try, 3 points. Guy's team:—

H. Millett, G. L. Steyn, G. H. Davies, J. Krige, B. C. Woodruffe, F. Bekker, G. Van Schalwyck, W. D. Doherty, F. W. Reitz, A. H. Shellswell, G. R. Aspinwall, L. K. Watson, A. Marais, G. Zondagh, E. E. Neser.

GUY'S v. CATFORD BRIDGE.

It was a great change after five years of war to be able to play a game against the neighbouring team of Catford Bridge at Honor Oak Park again. The teams had altered since 1914 and probably only two Catford men, H. E. Wilkins (Captain) and L. F. Tribe, and one Guy's man, had played in this annual encounter before. Still, one must not ruminate too much on the past, but be thankful that "Rugby" is with us again. Guy's turned out a very warm side indeed, and it was a pity that their opponents were not more strongly represented, but the railway trouble and the season's youth made this impossible. It was very sporting of Wilkins to get a side together, facing in the attempt so many difficulties.

From the first kick almost, Guy's went ahead. The whole team were on their toes and eager to show their mettle. This was not long hidden, as points rapidly began to accumulate, the run of the game coming to the right so that J. Krige and Steyn saw much of the ball and made the most use of it. It was J. Krige who opened the scoring, a return pass coming to him from Steyn. The hefty Marais was the next to get a try, followed before half-time by another from J. Krige and one each from Steyn and Van Schalwych. This last effort was finely carried through. Starting in mid-field, the stand-off half got away, neatly dodging and sidestepping past the full back, the final sprint being done at top speed.

After the interval, tries came from P. Krige, Reitz, Aspinwall, Steyn a couple, and J. Krige a couple, so that the final score stood at 4 goals and 8 tries to nil. By this it will be seen that only 4 out of the 12 tries were converted. This is not a good average, and one hopes that the goal-finding will be soon on a higher level. True, the try is the actual score, but the total points are much greater where the goal kicking is good. Steyn's try that he got early in the second half was a fine effort. He ran well down the wing and beat the full-back with ease.

It will be interesting to see Guy's against a team of tacklers, but I believe it will only serve to bring them out still better. One forward did not seem to push his weight, though in the loose they were distinctly good; the rushes, however, might be more compactly carried out. Practice will soon do that. All the back division played well. Olivier may congratulate himself it was not a cold day. Score —Guy's, 4 goals 8 tries, 44 points; Catford nil.

W. Olivier, G. L. Steyn, J. Krige, P. Krige, G. Schollum, F. Bekker, W. G. Van Schalwych, W. D. Doherty, F. W. Reitz, A. H. Shellswell, G. R. Aspinwall, C. E. Marais, W. Paw, L. K. Watson.

GUY'S "A" v. ROSSLYN PARK "A."

Guy's "A" are to be congratulated on turning out at full strength, despite the difficulties of strike transport, to play Rosslyn Park at the Old Deer Park, Richmond, on Saturday, October 4th.

Guy's kicked off against the sun and kept their opponents in their own half for the majority of the first half of the game. The only score up to half-time was a try by Laver as the result of a good forward rush.

After half-time Guy's dominated the game for a short time and scored two unconverted tries through Van Niehhurh and Van Zyl. Rosslyn Park then had a spell of attacking, culminating in a nice try in the corner. From the drop-out Guy's rushed play to the other end, and Morrison touched down from a forward rush, Van Niehhurh converting. A fast game ended in the score of—Guy's "A" 14 points; Rosslyn Park 3 points.

The Guy's forwards were good on the whole, but were poor in the line-outs and were slow in coming back to assist the defence. The outsides failed to take advantage of their numerous chances through bad combination, due to lack of experience and understanding.

ASSOCIATION.

GUY'S v. OLD WILSONIANS.

Played at Honor Oak Park on Saturday, October 11th. Although Guy's were not at full strength, they won very comfortably by 5 goals to 1.

Play never reached a very high standard, in fact, it was more of the kick and rush order all the way through. As a result of erratic kicking, the ball was kept in the air far too much. There was very little combination, and players were very apt to wander all over the field, instead of sticking to their position; many good opportunities were thrown away in this manner. Lindsay stood out very prominently for Guy's, his individual efforts being exceptionally brilliant. His untiring energy had a great deal to do with the result. O'Meara was the best of the halves and tackled very well. The backs, although fairly sound, remained too far back. They would have been of far greater value had they supported the halves more. The wing men were very weak. Hore had little to do in goal. However, he had two or three very difficult shots to save, but cleared very effectively. He had no chance with the penalty by which the visitors scored their only goal.

Goals were scored by Borrie (3) and Van Geuns (2). Team :—

W. Hore; F. Rayner, G. Pimm; I. Rosenberg, D. P. O'Meara, A. Riddolls; H. Evans, R. Van Geuns, S. Borrie, G. P. Lindsay (captain), F. R. Payne.

Birth.

DOBSON.—On the 26th September, at Rambold House, Ilkley, the wife of Maurice R. Dobson, O.B.E., M.B., B.S., of a daughter.

Marriage.

SIDEBOTHAM—COX.—On October 9th, F. N. Sidebotham, surviving son of the late Mr. J. N. Sidebotham, of Bowdon, Altrincham, Cheshire, to Mrs. E. R. Cox, widow of the late Capt. E. R. Cox, and only daughter of Mr. and Mrs. Edmund B. Traill, of Newland House, Eynsham, Oxon., and Chiro, Traill, F.C.C.C., Argentina.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 818.] NOVEMBER 15, 1919. [SIXPENCE.

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Passim.

ON Thursday, November 6th, Sir William Hale White delivered the Inaugural Address of the Pupils' Physical Society. Everyone who was present thoroughly enjoyed themselves, and it is difficult to say which was the more pleasing, to see Sir William back amongst us once more, or to listen to his exceedingly interesting paper. As the meeting clashed with others, many who wished to hear this were unable to be present, so that in our next two issues we propose publishing the address verbatim, half of the paper appearing in each issue. Before the paper, Messrs. Down Bros., Ltd., and Mr. Grattan gave an exhibition of instruments and books in the Library.

THE College Library, which has been closed during the war, will shortly be re-opened, under the care of Mr. Winston. An account will be opened with Mudie's again, and periodicals will be taken in for the Reading Room. If any Guy's man, past or present, has any books of fiction, philosophy, poetry, etc—in fact, any books that are not medical—which he does not want, they would be very gratefully received by the Librarian, the College.

ATTENTION is drawn to the re-arrangement of the Notice Board in the Colonnade. It will be seen that each Department is to have two spaces allotted to it. In the left hand space permanent notices, such as standing orders, etc., are to be posted, while the right hand space will be devoted to temporary notices. It is very gratifying to note this cleansing of the Augean Stables, as some months ago attention was called in the GAZETTE to the dilapidated condition of the Notice Board.

ON the evening of November 5th an unofficial firework display was given in the Park. Many of the younger patients thoroughly enjoyed the show, as, apparently, did the enthusiasts who were giving it. The site of the proceedings, however, was somewhat unfortunate, for it took place just beneath the windows of Hunt's House, in which shell-shocked soldiers, choreic children, and numbers of heart cases were trying to rest. Cannon crackers in the doors of the Medical block did not add to the calmness and peacefulness of the atmosphere. And so we venture to suggest that in future a more suitable place might be selected for these displays.

Similarly, now that Christmas is drawing near, and the Niggers are commencing to

practise, the suggestion has been put forward that one ward on the Medical side and one ward on the Surgical side should be reserved for bad cases, and that the Niggers should not go round these wards. There is much to be said for such a scheme, as will be apparent to all who have the welfare of the patients at heart, and may we hope that there will be a haven of refuge, far from the sound of the big drum, for those who are too ill to appreciate the entertainment.

It is with great regret that the Hospital bids farewell to the Rev. A. E. Popham, who for the past few months has resumed the office of chaplain, which he left to go on active service. Mr. Popham will carry with him the good wishes of all—the nurses, the men, and the patients. We trust that as he is only to be "across the way," at St. Saviour's College, he will find time to pay us many unofficial visits.

Speaking before the Eighth Annual Conference of the British Commercial Gas Association in London on October 28th, Dr. C. W. Saleeby, F.R.S. Edin., said that though we had at last a Ministry of Health it had not been able to do very much. But it had published ideas of what it proposed to do in the future. Its latest production, he said, waving a cumbrous volume before his audience, indicated the various ways in which it was going to work to create healthy people, but there was little reference to the question of smoke. Much was said about pure water, but little about pure air. That was characteristic of this country, because we had been brought up in the smoke and were satisfied with it.

We thought of Coal as a fuel, but a chemist would tell us that coal was a treasure house of a thousand valuable things, and that to burn it is barbaric folly. One could imagine a barbarian coming along and seeing the British Museum with all its treasures and being ignorant enough to say: "Here is something that will burn; let us make a fire." To burn crude coal and destroy thereby its latent treasures is, said Dr. Saleeby, just as short-sighted and criminal as to burn any other repository of irreplaceable wealth.

We should extract from coal the dyes, and drugs, and other valuable properties which it contains and burn the residue as fuel. He advocated the increased use of gas, the spirit of coal, in place of crude coal for all domestic and industrial purposes, and urged that this question should be fully considered in dealing with the projected housing schemes.

Review.

Notes on Galvanism and Faradism.—2nd edition, by E. M. Magill, M.B., B.S. Messrs. H. K. Lewis and Co., Ltd. (6s. net.).

Dr. Magill's "Notes on Galvanism and Faradism" is a book of a very different type, but its usefulness is shown by the fact that the first edition was reprinted twice, and a second edition has now been reached. The book is accurately described by its title, but in view of the fact that it is now used almost entirely as the text book for the Electrical Examinations of the Institute of Trained Masseuses, we think it might very well be less condensed than it is. In particular, Chapter VII. is so short that it must be difficult for the student with no previous knowledge of electricity to understand it, and we are surprised that the statement made that an ampere is "that volume of current which . . " can have survived in a second edition. Those parts of the book which describe actual medical parts of the subject are far more satisfactory, and give a well-balanced and up-to-date account of the subject of medical electricity at the present time.

Two Cases of Jaundice.

CLINICAL DEMONSTRATION BY DR. J. LAWCETT, Oct. 1st, 1919.

CASE I.—*Cirrhosis of the Liver in a chi'd.*

GENTLEMEN,—The first case I want to show you to-day is that of a little girl aged 10 years. There is no history of any serious illness previous to the onset of her present trouble, except a doubtful pleurisy when she was 7 years old. For the past two years she has complained of frontal headaches, and has also had frequent attacks of epistaxis, though not since she was admitted into the hospital.

Since the beginning of the year she has had diarrhœa frequently, attributed, by her mother, to the large amount of fruit which she ate.

On May 29th, 1919, she was seen in the Out-Patient Department complaining of acute abdominal pain. Slight jaundice was observed, and I learnt that the liver and spleen were palpable. Six days later the child's mother noticed that the abdomen was becoming larger, and on the day following that the legs were swollen. The jaundice increased and from time to time the child vomited. She was admitted under my care on June 11th last.

On admission there was, and still is, slight jaundice of the conjunctivæ; the skin also was similarly tinted. There was considerable swelling of the abdomen, due to ascites, and some œdema round the ankles. The superficial veins on the abdomen and thorax were somewhat dilated. There is a very interesting feature which I wish you specially to look at: she has a number of little "angiomata," or "spider nævi," most prominent on the arms and hands. In addition, there is a pustular follicular infection of her face, of a rosaceous type.

I could not feel the spleen when the patient entered the hospital, but later on one occasion, after "tapping" had been performed, the spleen was felt to be enlarged. The liver I could feel; I should not call it an enlarged liver, but rather a small hard liver, as the edge was not palpable at the costal margin, but it was distinctly palpable in the epigastrium just below the xiphoid cartilage; it felt very hard, and as if its edge were somewhat turned upwards.

The condition of the urine is summed up in Dr. Ryffel's report: Specific gravity was 1026, acid, with deposit of urates, and it contained urobilin, uroerythrin, bile pigment, and a small quantity of albumen. Dr. Ryffel also kindly examined for us a specimen from a 24-hour collection of urine, to see if there was any evidence of disease in the pancreas. On this occasion he reported that the specific gravity was 1028, and that "the diastase index was 33, which, considering the concentration of the urine, probably is not above normal." He also found that the urine reduced Fehling's solution slightly, and yielded an ozazone, crystallising in stars, which may mean a small yield of dextrozazone.

About three weeks after admission the abdomen was "tapped," and many pints of fluid removed. Examination of the fluid showed it had a specific gravity of 1010, containing protein ·8 per cent. and a small quantity of sugar, namely, ·1 per cent. Also, like the urine, it contained urobilin and bile pigment. The fæces showed a moderate stercobilin spectrum, less than normal, the colour lighter, and there was no excess of fatty acid or of soap crystals.

The other investigation which we had made was for a "Wassermann reaction," which was positive, though not strongly so.

Thus here we have a patient with certain features, which I will presently demonstrate to you, a history of repeated epistaxis, slight jaundice, considerable ascites of comparatively recent appearance, with bile and a trace of albumen and sugar in the urine. The liver was small and hard, the spleen was enlarged; "spider nævi" and a follicular eruption on the face represented the involvement of the skin. The blood gave a positive Wassermann reaction. There was no marked anæmia.

The child's condition has not altered materially. Paracentesis has been performed about once a month during the past four months.

I now want to draw your attention to the temperature chart. The temperature has always been a little raised, up to 99° and 100°, though lately it has been rather lower. There is so much ascites at the present time that the liver is not palpable, even by "dipping." You will notice that there is no angiomatous formation around the umbilicus, nor about the lower costal margin.

Diagnosis.—There are, as you know, three groups of cases which are associated with ascites. I do not propose to discuss those groupings to-day, suffice it to say that we

could not find any signs of disease in heart or lungs, nor of renal disease. Nor to my mind is there any evidence that a chronic peritonitis explained the ascites and the other features of the case. Therefore, we fall back upon the liver as the primary seat, and in support of this the association of a small hard organ accompanied by a large spleen, ascites, slight jaundice, and bile in the blood and urine are the features upon which we rely. If such characters had been met with in an adult, I do not think any one of you would have hesitated to declare that the case was one of "cirrhosis," probably of alcoholic origin. But in this case there is neither suspicion nor suggestion that alcohol is the cause; and undoubtedly there are cases of portal cirrhosis which are not associated with excessive indulgence in alcohol. Nevertheless, that this case is one of "portal cirrhosis" there can, I think, be little doubt.

We have now to consider the factors which produced it, and we first take *syphilis*, because, as you will remember, the Wassermann test gave a positive reaction. What forms of liver disease does syphilis give rise to? First, there is the unicellular or pericellular cirrhosis in infants, which is associated with other signs of congenital syphilis, such as rashes. Apparently, such cases may recover, and it has been suggested that the resistance of the liver has been lowered by the original syphilitic infection, thus rendering the organ more likely to undergo cirrhotic changes in later life. I do not think the present case can be considered to be the result of infantile congenital unicellular cirrhosis.

The next group is connected with what we may call the delayed or later manifestations of congenital syphilis. In that form the results are produced in exactly the same way as in acquired syphilis, that is to say, we may meet with a scarred fibrous irregular liver with gummatous deposits in it. One of the first of these cases was recorded by Sir Samuel Wilks many years ago; it was a scarred liver containing gummata, just like an acquired syphilitic liver in an adult.

A third group which is said to follow a congenital syphilitic infection is that in which there is a multilobular cirrhosis of the ordinary "hobnailed" type, a granular cirrhotic liver, without gummata or scars and in which there are also signs of congenital syphilis elsewhere in the body. All I can say is, that, apart from the positive Wassermann reaction, there is no evidence of syphilis in this child. It is true that direct evidence of congenital syphilis in the way of keratitis, notched teeth, and so on, may be absent. Apart from the blood test, there is no evidence of that disease in our patient, past or present, no keratitis, no Hutchinsonian teeth, no bone disease, nor other of the common manifestations of congenital syphilis. I do not think that this is the cause in the case under consideration.

I now want to return to the question of portal cirrhosis, that is, the ordinary cirrhotic liver; to remind you of other causes than those already referred to, and to consider with you whether any of them may be factors in this girl's case.

We know multilobular cirrhosis may be induced by alcohol, probably not directly, but in some indirect way. In cases associated with alcohol, it is suggested that the alcohol sets up some gastro-intestinal irritation, resulting in the formation of "poisons," which, carried by the portal vein to the liver, produce cirrhosis Although we know little or nothing of their exact pathology, it is certain that there are "poisons" apart from alcohol which set up cirrhosis. For example, Rolleston in his Treatise on "Diseases of the Liver," drew attention to the fact that amongst high-class Hindus multilobular cirrhosis is recognised fairly frequently, yet this class of people do not, as a rule, touch alcohol. The same is true of Mohammedans. It is interesting, he remarks, to remember that many of those people are fond of highly-spiced things, and these may be producing poisons which act as intestinal irritants in the same way as does alcohol, and also that in Egypt and India liability to infection from other poisons does exist, for example, malaria.

Again, we know that certain chemical poisons will cause cirrhosis, for example, arsenic and trinitro-toluene. Experimental injection of bacterial poisons into animals has also produced cirrhosis.

Then think of the spleen and of conditions in which—at any rate for the purposes of this lecture—we may regard the spleen as the primary seat of the disease, and cirrhosis of the liver as a secondary development, e.g., cases of "Banti's disease," a late development in the

course of "splenic anæmia," associated with ascites and jaundice. Again, in malaria, there is no doubt that in some cases (though rarely) cirrhosis may ensue.

Also I would draw your attention to other "poisons" which may gain access to the liver, not through the portal circulation, but through the general systemic circulation, for example, in some of the specific fevers. From time to time we meet with cases in which the liver presents the characters of a small "hobnailed" organ indistinguishable from that due to alcohol, and yet the only traceable illness has been typhoid or scarlet fever, or measles. We know that "typhoid" and other specific fevers may cause necrosis of portions or islands of liver tissue, and that experimentally the injection even of vegetable poisons may cause cirrhosis of the liver.

The lesson of all this is, that when you see a case of ascites which you think is due to a contracted "hobnailed" liver you must not at once attribute it to alcohol. Whether in this case it is a syphilitic cirrhosis, in which there is no sufficient evidence of syphilis, I do not know; but I am inclined to think, in the absence of manifestations of syphilitic disease, that the case is one due to "portal cirrhosis" of unknown origin.

Other possible causes which we took into consideration in our discussion were (1) Chronic peritonitis and perihepatitis. The occurrence of epistaxis, the "spider nævi," and the slight degree of jaundice led me to exclude chronic peritonitis as the primary cause, though it is possible there may be chronic perihepatitis and peritonitis as well as cirrhosis.

(2) The presence of "sugar" in the urine suggested a primary lesion of the pancreas, a pancreatitis. But, as I have told you already, the "diastase index" in the urine could not be regarded as above the normal, and there was nothing in the examination of the fæces to indicate a lesion of the pancreas.

(3) Another condition (again brought to our minds by the presence of glycosuria) but only to be as quickly excluded, was hæmochromatosis, or diabete bronzé, as the French call it. In this condition there is usually great enlargement of liver and spleen, associated with general pigmentation of the body and of many of the viscera; in its later stages it may be associated with severe diabetes. It is manifest that this patient has no excessive pigmentation, nor a big liver, and the amount of sugar in her urine was too small to need serious consideration.

To recapitulate the main features of the case as characterising cirrhosis of the liver, there is the bloated appearance of the face, which is so characteristic of cirrhosis, and the rosaceous eruption, dilatation of superficial veins in the form of "spider nævi," which, though mentioned in many text-books, are, to my mind, somewhat rare, the slight jaundice, and, a point I forgot to mention previously, the dry harsh skin. A little albuminuria is frequently present, probably of toxic origin. In the absence of renal disease it is of no special import. The patient also suffered from diarrhœa, which is often present in cases of cirrhosis.

Treatment.—We have been quite unable to influence the course of the case by treatment. Diuretics, iodide of potassium and mercury in view of the "positive Wassermann," have not availed, and now we are about to administer small doses of neo-salvarsan, but we shall proceed very cautiously, as much liver tissue is probably already thrown out of gear. Paracentesis abdominis has been performed for the relief of the ascites when required.

CASE II.—*Chronic Acholuric Jaundice.*

The next case also is of considerable interest. The patient is a girl, æt. 19, and she states she was in good health until $3\frac{1}{2}$ years ago, when she had tonsilitis. Her tonsils were afterwards removed. About $2\frac{1}{2}$ years ago she went to see an old Guy's man, Dr. Stebbing, on account of profuse menorrhagia and what she called severe "bilious attacks," and jaundice. The attacks varied in duration from a few days to several weeks, and were accompanied by severe headache, vomiting, and giddiness, and the jaundice became more marked.

When Dr. Stebbing examined her he found the spleen enlarged, extending about 2 inches below the costal margin. At first (for about a year) the attacks of headache and increasing jaundice occurred about once a month, and then for the nine months following about once a week. The patient has had no attack for the past six months. The menorrhagia was so severe that she was admitted into the hospital, under the care of Mr. Bellingham Smith, as it was thought there might be some organic cause to account for it, but none was found. During the past year, although the "periods" have been profuse, they have been regular.

The patient is, as you can see, a person of slight build, of rather pallid complexion, with a distinct tinge of jaundice of the conjunctiva, permanent for the past two years or more, deeper in tint at times. The jaundice was rather more marked on admission two months ago than it is at present. The spleen is enlarged, and it can be felt an inch below the costal margin. The liver is not palpable and is not enlarged. There are no signs of disease elsewhere on physical examination. The visible mucous membranes are pale. The patient complains of frequent attacks of pain in the lower left portion of her thorax, over the splenic region, which are sufficiently severe to keep her awake, or wake her up, and for which we cannot find a cause, unless it be some inflammation of the capsule of the enlarged spleen.

Now let us turn to the examination of the urine on which we have received four special reports from Dr. Ryffel. In three of them the specific gravity varied from 1020 to 1027; there was a slight excess of urobilin, but no bile pigment nor other abnormal constituent. Neither did the fourth examination reveal bile pigment, but there were a few pus cells present and a trace of albumen, which I do not regard as possessing any special significance. The blood which was examined on two occasions showed urobilin in considerable amount, and only a slight trace of bile pigment. Thus, you will remember, please, that although there was a trace of bile pigment in the blood, there was not sufficient to be excreted in the urine. The Wassermann reaction was negative.

Dr. Nicholson examined the blood for us on two occasions, namely, on August 31st and September 9th, with the following results: hæmoglobin 104 per cent. and 94 per cent.; red blood corpuscles 3,780,000 and 4,000,000; white blood corpuscles—there was a slight leucocytosis—10,720 and 8,733; colour index 1·4 and 1·2.

You will notice there was considerable destruction of red cells, but they contained their full complement of hæmoglobin, giving a high colour index. There was a somewhat high leucocyte count. There is nothing of special significance in the differential count of the white cells. There was one erythroblast and one normoblast, and a moderate degree of anisocytis.

The main features of the case are, that the girl has splenomegaly, associated with chronic slight jaundice and urobilinuria, but without bile pigment in the urine; definite evidence of hæmolysis is seen from the "blood-count." In other words, the condition corresponds with that symptom-group which we know as "chronic acholuric jaundice with splenomegaly"; or, as some prefer to call it, "chronic hæmolytic jaundice without bile pigment in the urine." The case is an excellent one to put side by side with that previously shown. In the second case we have a hæmolytic anæmia, chronic slight jaundice associated with an enlargement of the spleen, but none of the liver, and no bile in the urine. In the first case slight jaundice was associated with a disease of the liver, and bile pigment was present in the urine and the blood.

As is usual in this group, there is no evidence of a syphilitic infection. The patient was brought into the theatre and the clinical features demonstrated. Chronic acholuric jaundice is a rare affection. The condition was first brought prominently to our notice by a study of a group of congenital cases, in which one or more members of a family were affected, extending over different generations. The characters of the group are well narrated in two papers in the *Lancet* for the year 1910; one by Dr. F. J. Poynton, under the title of Congenital Family Cholæmia, and the other paper by Dr. F. Parkes Weber, under the term Congenital Acholuric Jaundice.

What I want to impress upon you is, that in the congenital group the jaundice appears usually soon after birth, and persists, as a rule; that exacerbations occur from time to time in which the jaundice becomes more marked, and that this jaundice—unless it is excessive—is not accompanied by the presence of bile in the urine. The spleen is enlarged, the liver is not affected. This statement puts the matter very dogmatically, for there are cases in which the anæmia—always present in some degree—is sometimes severe, and when the jaundice is increased, a little bile pigment may be excreted in the urine.

As a rule, the patients maintain a very fair condition of general health, so that they are able to carry out their work efficiently except during an exacerbation period, and they may live to a good old age.

There are other cases in which there is no congenital or hereditary element, and, clinically they are like the congenital group. In the case of our patient there is no family his-

tory of the condition, and yet she corresponds closely, as you have heard, to the congenital or familial group.

However, in some of the acquired cases the illness is of a far more severe type, the patient's general health suffers materially, and the anæmia becomes more intense than in congenital cases.

So far as the progress of our patient is concerned, it cannot be said to be by any means satisfactory, although her general health has improved somewhat. The attacks of pain in the splenic region disappear for a time only to reappear again later. Although she has been under treatment with arsenic and other drugs for some two months, yet the destruction of the red cells continues. The question we have now to decide is whether an attempt should be made to remove the spleen. A number of successful cases of removal are on record (v. Proc. Royal Society of Medicine, 1914). Splenectomy is a serious operation and requires very mature consideration, and in discussing it with the surgeon we shall, from our point of view, urge that the attempt to remove it, if decided upon, should not be persisted in if the spleen is found to be very adherent to adjacent structures.

In reference to the pathology, we know little or nothing. The suggestion has been made that there is an abnormality in function of the red marrow, and consequently the red cells exhibit less resistance than normally to hæmolytic influences. This destruction of red cells throws a greater strain upon the spleen, which in consequence enlarges. The hæmolysis results in an increased formation of bile pigment by the liver, the jaundice and urobilinuria being the result.

The fact that some of the cases in which the spleen has been removed have been much improved thereby, seems to indicate that the spleen is the primary seat of the disorder.

Note—Case I.—At the end of October, after consultation with Mr. Turner, it was decided to recommend the performance of a small operation with the idea of encouraging the development of a collateral circulation and so remedying the ascites. The fluid in the abdomen was re-collecting more rapidly, and there was nothing left for us to do except to "tap" the abdomen more frequently.

Mr. Turner agreed to insert and fix a portion of the great omentum in the sheath of the rectus muscle. The operation was performed under "gas and oxygen." Our hopes were disappointed, and the child died a day or two later.

This case emphasises the danger of surgical intervention in cirrhosis of the liver, for, although the child's general condition was, as I thought, quite equal to so small an operation, yet I was wrong, as the event proved.

At the autopsy the liver presented the character of a much contracted "hobnailed" organ with considerable compensatory hypertrophy of some of the remaining liver tissue. The left lobe was larger than the right; the organ weighed 15 ounces. The capsule was a little opaque in places, but there was no increase in thickness such as is met with in cases of perihepatitis. No gummata were present, nor any marks of syphilis in the liver or elsewhere. The spleen was enlarged, about half as big again as normal.

Papers by Guy's Men.

Sir Charters J. Symonds, K.B.E., C.B.: Removal of tonsils and adenoids.—*B.M.J.*, Nov. 1st, 1919.

Capt. E. Hunt ley, R.A.M.C.: Rupture of large intestine—operation—death.—*Ibid.*

W. G. Nash, F.R.C.S.: A giant mucocele of the appendix.—*Ibid.* Nov. 8th.

L. G. Davies, M.D.: Calcium Chloride as a hæmostatic.—*Ibid.*

Lieut.-Col. A. F. Hurst, M.D.: An address on hysteria in the light of the experiences of war. Delivered before the American Neurological Association.—*Lancet.* Nov. 1st.

J. F. W. Silk, M.D.: Nurse Anæsthetists.—*Ibid.*

Reports of cases shown at the Royal Society of Medicine.—*Proc. R.S.M.* August, 1919:—

P. Turner, M.S.—Children's Sect., p. 60.
W. S. Handley, M.S.—Clinical Sect., p. 19.
W. M. Mollison, M.Ch.—Laryngol. Sect., p. 211.
T. B. Layton, M.S.—*Ibid*, p. 214.
W. H. Jewell, M.S.—*Ibid*, p. 215.
J. D. Malcolm, M.D.—Obst. and Gynæ. Sect., p. 179.
T. G. Stevens, M.D.—*Ibid* p. 189.
F. N. Doubleday, L.D.S.—Odont. Sect., p. 101.
A. W. Ormond, M.S.—Ophthalmol. Sect., p. 37.
G. Maxted.—*Ibid*, p. 42.
P. P. Cole, F.R.C.S.—Surgical Sect., Sub-Sect. Proctology, p. 45.
W. S. Handley, M.S.—*Ibid*, p. 46.

Leaves from a Medical Note Book

(1914—1918).

VII. A Case of Anaphylactic Shock.

In spite of the innumerable doses of anti-tetanic serum given in the course of the war, and the very frequent instances of repeated dosage in individual cases, grave anaphylaxis was a very rare event. So rare was it, in fact, that the possibility of its occurring came to be regarded as remote, and in some minds the phenomenon was considered as more or less of a "bogey." Doubtless the explanation of its infrequency was the smallness of the customary prophylactic dose, and the fact that it was not administered by the intravenous route. When, however, in 1918, the initial dose was raised from 500 or 750 units to 1,500 units there is reason to believe that cases of true anaphylactic shock occurred.

The following case was an instance:—A man was admitted to a main dressing station at Meteren during the fighting in front of Bailleul in September, 1918, with a small superficial wound on the buttock. He was, however, in such a serious state of collapse, with vomiting, pallor, sweating and imperceptible pulse, that the wound was investigated with very special care in order to exclude all possibility of an intra-abdominal lesion or deep hæmorrhage. He had slight upper abdominal pain, but this appeared to be due to the strain of vomiting. At the apex the heart could be heard beating rapidly, but the sounds were very faint. Mentally the patient was quite clear. He had had anti-tetanic serum at the advanced dressing station half an hour before, and his previous history was elicited as follows: On two or three occasions for wounding or trench feet he had had anti-tetanic serum, and on each occasion had felt very ill as the result. A diagnosis of anaphylactic shock was therefore made.

He was treated by warmth (*e.g.*, blankets and a hot-air bath) and given hot drinks and alkaline draughts, but as after two or three hours he showed no obvious improvement, and his radial pulse was still impalpable, it was decided to send him on to the Casualty Clearing Station. Before he was put into the ambulance car he developed an almost universal urticarial rash, which further supported the diagnosis.

A note was received later from the Casualty Clearing Station stating that he had arrived there in much the same condition as described above, but by the next day was so nearly normal again as to be considered fit for evacuation to the base.

It need hardly be added that he was strictly advised to refuse any further treatment with serum.

(To be continued).

Pass List.

University of Cambridge.

D.P.H.—October, 1919.

Part I.

R. J. Hearn.

Conjoint Examination.

October, 1919.

Medicine.

N. V. Wadsworth	*L. Lavine
A. C. M. Coxon	*H. T. Le Vieux
*R. C. B. Ledlie	*W. H. Dixon
*W. S. R. Thomas	W. M. Brown

Surgery.

*L. Lavine	*H. C. Hopkinson
*H. T. Le Vieux	*W. G. Hay
H. A. A. Pargeter	*R. B. P. Lansdown
*S. Rose	*H. G. Burford
*K. M. K. Duff	*C. G. D. Siggs
*W. W. Payne	*A. K. Day-Lewis
*J. V. C. Braithwaite	*W. J. M. Allan
G. P. Lindsay	

Midwifery.

*L. Lavine	T. Reed
H. A. A. Pargeter	S. Cohen
E. E. D. Gray	

*Denotes completion of Examination.

Society of Apothecaries of London.

October, 1919.

Medicine—G. K. Reeves.
Midwifery—J. E. Barrie.

Honours.

Foreign Decorations.

FRENCH.

Légion d'Honneur—Officier.—Major-General E. G. Browne, C.B., C.M.G., late R.A.M.C.

PORTUGESE.

Military Order of Avis-Commander.—Temp. Major and Brevet Lieut.-Col. F. S. Brereton, C.B.E., R.A.M.C.

The Future of the R.A.M.C.*

It is probable that never before this war has over half of a learned profession been temporarily placed in utter subservience to a very small State Service. This has been the lot of the civilian medical profession in England during the last five years, and the occasion has afforded ample opportunity to both civil and military doctors of making each others acquaintance, and of mutual criticism. And the contrast of ideas has been the more remarkable inasmuch as the civilian medical community is highly individualistic, whereas in the Royal Army Medical Corps individuality is almost considered as the sin of witchcraft.

During the war the civilian doctors under military discipline have been of necessity inarticulate, and now that the war is over that is a danger that in the stress of getting back into the ordinary stride of civilian medical work those who were acute and eager critics of the R.A.M.C. will remain silent, and the next war will find the same misunderstandings and defects uncorrected. It appears essential that this silence should not be encouraged, for it is certain that the medical profession will be swept into military service in future wars, and it is of the utmost importance that in such an event the medical brains of the country should be rapidly and efficiently organised and that there should be no repetition of the waste and misapplication of specialised personnel that has characterised the R.A.M.C. in this war. It is for this reason that Sir James Barrett's book is very welcome. A distinguished specialist in the University of Melbourne, a well-known Australian publicist, and an ardent educationalist, he speaks with knowledge and authority; he is also free from any imputation that he is a disappointed man, or one whose services have not been adequately recognised, as his military decorations well show. He is in a position, therefore, to speak for his professional brethren, many of whom have not had liberty either of speech or of action in the last five years.

His book is divided into two parts, of which the latter is the more important, as it deals with the future of the R.A.M.C. The first part of the book gives a resumé of Sir James Barrett's personal experiences as a Consulting Oculist and Aurist to the Forces in Egypt, as President of the Standing Medical Board in Cairo for Classification, Invaliding and Repatriation, and as a Member of the Council of the British Red Cross Society in Egypt; a very detailed and interesting account is given of the work done in some of the special departments of medicine and surgery, and also of the way in which the problem of standardising classification and invaliding was effected in the Egyptian Expeditionary Force by the establishment of Standing Medical Boards, a movement in which Sir James Barrett took a distinguished and prominent part.

What more concerns the students of the Medical School of Guy's Hospital is the latter portion of the book, in which the writer criticises the R.A.M.C. as he saw it from his own special standpoint, or from the point of view of the many other temporary medical officers with whom he came in contact.

In his preface Sir James Barrett says, "It is quite certain that Great Britain and the Empire will require an army in the future, and it is quite certain that a highly trained and efficient R.A.M.C. will be necessary. How is it to be recruited? If there is one attitude more characteristic than another of some of the distinguished civilian medical practitioners who have served in Egypt during the past three years, it is that they will not recommend any young men who mean to take medicine seriously to join the R.A.M.C. as it is at present constituted. As one of them put it, "any decent young man who wants to live in different parts of the world, who is fond of hunting, riding, fishing and shooting, and who is prepared to do a fair day's work, may be recommended to join the R.A.M.C. Those who mean to make medicine and surgery the preoccupation of their lives had better stay out of it."

The reason for this opinion, which has been very generally formed by able civilians who have served in the R.A.M.C. is that there is very little *encouragement, and no future, in professional* medicine and surgery in the R.A.M.C. and that the methods of promotion are hopeless. One distinguished consultant in Egypt remarked that as far as he could see promotion in the R.A.M.C. was by *blood pressure only!* This is really a very fair criticism of a service in which promotion in the higher ranks is by seniority alone.

These views are of great importance also in connection with present discussions as to the establishment of a State Medical Service, for the R.A.M.C. is a State medical service and all state services are very much alike. As Sir James Barrett says, "Is it not clear that an Army Medical Service should lead the world in scientific medicine? The conditions are ideal, since men are provided with fair salaries and a guarantee against want in the form of a pension; they have abundant leisure, they have hospitals and laboratories at their disposal, and the patients are under discipline. Can

*A Vision of the Possible; What the R.A.M.C. might become. By Sir James W. Barrett, K.B.E., C.B., C.M.G., late Lieut.-Colonel, R.A.M.C., pp. 182, Plate and two Maps. Demy 8vo. 9/- net. (Messrs. H. K. Lewis).

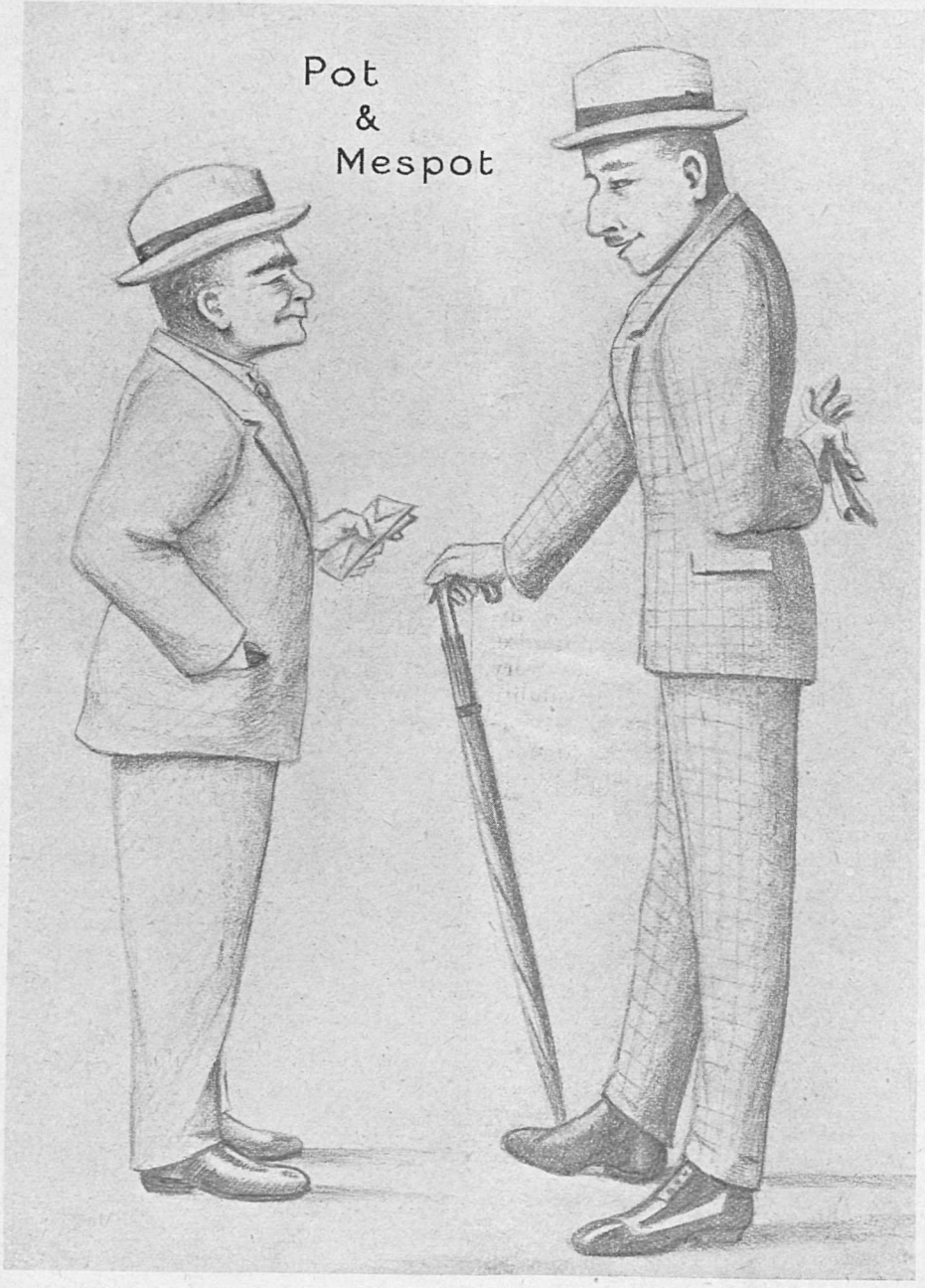
any human being imagine conditions better fitted for the development of a thorough knowledge of medicine, both on its curative and on its preventive side? There should be simply no limitation to the nature of the problems they can attack, and such a service should easily lead the world. Yet what has the R.A.M.C. done? I do not overlook certain brilliant and individual instances of development, but in the main what has been the scientific output from the R.A.M.C. compared with that from any similar group of privileged medical men? The best test to apply to the result is to ask oneself how many medical practitioners not members of the military service ever think of turning to the R.A.M.C. for guidance."

One of the great defects of the R.A.M.C. as has been observed during the war, is the constant change of personnel, absolutely inexplicable to those who know the value of good team work in a civilian general hospital. Sir James Barrett says, "During the four years I have served in Egypt, I found myself under the control of no less than ten Directors of Medical Services, eight of them direct and two indirect—that is to say, one was a subordinate D.M.S. and the other principal D.M.S. It is true that one of them only held office for a few days, another only for a few weeks, but the passage of chiefs reminded one of the procession of ghosts in Macbeth, and the changes in subordinate commands were on a similar scale. Now everyone is aware of the difficulty in war-time of securing continuity as in times of peace, but these constant changes served no good purpose." And as in the higher commands, so in the lower; medical officers were shifted about in the most kaleidoscopic manner, both in professional and administrative posts, and efficiency was often lost owing to medical officers being constantly forced to spend their time learning the details of their work in new and unfamiliar surroundings. There still existed in the minds of the older members of the regular R.A.M.C. the obsession that the ideal medical officer should be able to turn his hand to anything, and that specialism was anathema; consequently oculists were put in charge of mental cases, bacteriologists in surgical wards, and round pegs in square holes everywhere, as this method saved the mental and moral worry of determining the professional value of each individual.

The same reactionary ignorance was shown in promotion. As Sir James Barrett says, "In the R.A.M.C. there was no such thing as promotion for service in the class in which an officer was appointed; such has been the experience of the war. If a captain was made a Consulting Surgeon, as was the case, he became a lieutenant colonel, and then a colonel. If a captain was made a Consulting Dentist, as was the case, he remained a captain, because the position of Consulting Dentist did not carry any definite rank. If a captain in a hospital did magnificent clinical work, he could not obtain higher rank except by becoming Registrar or Divisional Officer—that is to say, by giving up part of his clinical work and taking up administrative work; in other words, excellence in a special department of knowledge could only be recognised by asking him to do something for which he might not be fit, mentally and by training. The reason for this system will be readily understood. It avoids intellectual and moral effort. It is possible to promote a man in this way irrespective of the value of his special services in his new post and in a way that cannot be challenged —that is, an excellent official reason can be given for it. If, on the other hand, it became necessary to promote a man for his own knowledge and lift him above the men around him, it would require careful adjudication and plenty of moral fibre to answer the criticisms of the disappointed; and yet, as I shall show later on, I know of a great service in which this is done, and done successfully. To me, the faulty mainspring of the R.A.M.C. lies in the moral abasement indicated by this attitude."

Broadly speaking, it may be said, that before the war, promotion above the rank of Major could only be for administrative work, and during the war promotion in almost any rank for clinical or professional efficiency was nearly impossible. The result was evident in the behaviour of the regular members of the R.A.M.C. They took to an office job as a duck takes to water, well recognising that in offices or administrative posts only were decorations or advancements to be obtained. The temporary member of the R.A.M.C. could, and did, do the actual work of saving the soldier's life, or of relieving him in sickness, but rewards for this work were few and far between and promotion almost unheard of.

Further it was pitiable, in a time when medical men were urgently needed, to see them occupied with office work which is done in civil hospitals by laymen. Registrars of hospitals need not be medical men, and most of the work of the D.A.D.M.S. in Egypt, nearly all healthy young members of the regular R.A.M.C., could be done by men without medical training. It was a waste of specialised material to have medical men looking after the movements of hospital trains or hospital ships, or acting as commanding officers of Medical Stores or Ambulance convoys. The consequence of this policy is becoming apparent with the demobilization of the temporary officers of the R.A.M.C. The regular members of the R.A.M.C. who had received special training before the war are now all too senior to hold clinical appointments and the younger men who joined during the war have received no train-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ing at all or have spent their time in offices forgetting all the medicine they ever knew. As a result there is a dearth of men with special qualifications, either for general medicine or surgery, or for special diseases, and as there is no future in these paths men do not readily take them.

It must not be forgotten, however, that there is one department of the R.A.M.C. for which I think all civilian members of the medical profession express unrestricted admiration, and that is the Sanitary Service. The health of the army in this war and the amazing efficiency of the means for prevention of disease are due to the Army Sanitarians. But, as Sir James Barrett points out, "The Sanitary Service of the R.A.M.C. is the Cinderella of the Service. He who takes it may get the satisfaction of doing splendid work, but he will receive neither the promotion nor the rewards which are given to the administrative service. The prevention of disease is never dramatic, people fail to visualise that which has not occurred, and the A.D.M.S. Sanitary in the Service at present occupies an indifferent third position (and the clinical element may be placed a bad second). A noteworthy case existed in Egypt where a Professor of Sanitary Science ultimately at his own wish was placed in command of a Field Ambulance for reasons that are indicated in the foregoing.'

There is no space here to enter into the details of the exasperating instances of the absence of either the will or the power to understand the civilian practitioner on the part of the regular members of the R.A.M.C. or of their failure to understand the trend of modern medicine in the necessary development of specialism; the main lines of criticism of the R.A.M.C. as it was constituted at the time that Sir James Barrett wrote his book have been set out above. Fortunately, as far as one can hear, criticism has borne fruit under the present Director General. Special Departments have been established in the R.A.M.C. for Hygiene and Pathology, each under a Director who ranks only lower than the D.G. himself. The organisation of each branch, the posting and promotion of personnel, and the direction of studies have been placed under the control of a board composed of both military and civil practitioners. If rumour is true, also, a scheme will shortly be produced which will permit an officer in the R.A.M.C. to choose definitely for his career either medicine, surgery or some speciality, and to remain in that branch if efficient, right up to the time that he becomes eligible for promotion to the rank of Major General. If this scheme is adopted and carried through fairly and courageously against all the tradition and prejudice in favour of the old R.A.M.C. theories that an officer should be able to turn his hand to anything, but, best of all, to a pen, then there will be more incentive to able young men to join the R.A.M.C. More important than all, however, in view of what has happened in the past, and of what may happen in the future, will be the duty of the R.A.M.C. to keep in touch with the progress of civil medicine, and with the outlook of civilian medical men. This can only be accomplished by some infusion of lay influence in the advisory councils of the R.A.M.C. and by the restoration to its proper position and influence of the Medical Advisory Board as it was constituted at the re-organisation of the R.A.M.C. after the South African war. Of late years and during the war this board was practically abolished, and the many failures of the Army Medical Service from 1914 to 1919 must be attributed to the absence of such an advisory body.

Those responsible for the education of medical students in the large schools and hospitals in London will wait anxiously for some evidence of the permanence and efficiency of the projected reforms before they can advise their students to join the Royal Army Medical Corps.

Appointments.

R.A.M.C.

Maj. A. S. Littlejohns to be Lieut.-Col. whilst specially employed.

Temp. Capt. K. N. Purkis, M.C., to be Capt.

R.N.

Surg. Rear Admiral W. W. Pryn is placed on the Retired List.

Civil.

C. Worster Drought, M.A., M.B., B.Ch., to be Hon. Neurologist to Out-Patients, Bethlem Royal Hospital, S.E.

Guy's Hospital War Memorial.

	£	s.	d.
Brought forward ...	5,001	17	4
Herbert, J. Rhys	1	1	0
Morres, F.	5	0	0
Parry-Jones, M.	10	10	0
Willan, R.	5	0	0
Bowes, E. S.	5	0	0
Olver, S. Holloway	5	5	0
Blake, G. Alan	5	0	0
	£5,038	13	4

Religion and Science.

On October the 16th Bishop Gore gave the first of the series of lectures on Religion. About a hundred men came, and, after Lord Goschen had introduced him, the Bishop began by saying that the best in the average man is feeling for the best way of co-operating with the best purpose. It is a moment of acute crisis. To whatever sphere you turn our hopes of recovery have not shown clear signs of realization. Men say we won the war, and so we shall win through now. But the great difference is this. During the war men in great masses abandoned freedom and fought to attain freedom. The initiative lay in the hands of a few. Now men have returned to civilian life, each is free to do as he pleases. The battle now has to be fought under conditions of liberty. Of course, the ideal for free men is a free communion. But how can freedom be realised? How can man make his life an instrument for a good purpose? By religion. The feeling that there is Divine Order, something in the universe working for good with which I can co-operate. All feel the need of this. My function is to co-operate. Huxley, Bertram Russell and Wells see nothing but blind law or something brutal and destructive. Huxley taught that man should fight against natural laws, Russell that he should live in defiance of nature. But if there is no purpose with which I can co-operate but only blind forces, what can be the use of puny man having anti-natural ideals, standing up against forces of universe which must swallow him up? That which is sphinx-like becomes intelligible in Christ. Read the Gospels. For the present ignore difficulties such as miracles. Let the impression of that Living Person become real and deep in your mind. Can a man repudiate that message given in such assurance, such love? It is the heart of Christian religion. But no man with such ideals can fail to be baffled. They do not work because of Sin. Nowadays people laugh at St. Paul, and say his doctrine of sin is exaggerated. Let us appeal to Shakespeare. Shakespeare, we find, does not differ from St. Paul in his teaching on the obsession of mankind by great passions. But he has no gospel! St. Paul shows us the way out. Christ is the Liberator from the power of evil, and Christ points us the way to true freedom.

On Tuesday, October 22nd, Canon Temple gave the second of the course of lectures on Religion and Science. Dr. Fawcett took the chair. The lecture created the greatest interest, and afterwards it was suggested by one in the audience that notes should be published.

Canon Temple began by saying that the subject was too large for exhaustive treatment. He could but give a few of the connecting ideas. Religion is not a science, and it is not reasonable to ask it to justify itself by scientific process, for science is an effort to understand facts and religion an effort to produce a result. It consists in making choices in the trust that God will support you. Faith and prayer lie outside science, and experiment alone will prove them. You cannot say "Prove first that God exists, and then I will say my prayers." The existence of God cannot be proved as the existence of oxygen can. To attempt to do so would be to exclude half the evidence, since half the evidence comes from the experience of prayer itself. It is the same, as a rule, in Art. The artist discovers his meaning in the process of expressing it. The religious view of the world is the most rational one. It was a philosophy and not a science in that it comprehends everything. The sciences deal with individual aspects of the universe. Each science has its own department. Philosophy attempts to deal with the whole. You arrive at your results in much the same way, for even in Science there is often no definite proof of accepted facts. Facts are collected and sifted until a law is arrived at. If all the facts are coherently systematised, there is the truth. This can be applied to the world. Every cause is also an effect. But there is no cause or explanation, in this sense, of the whole series of causes and effects. That can only be explained by a principle which does not itself require explanation. But just as in Science you apply certain known facts to elucidate difficulties, so you could in this case. There is in our experience one, and only one, self-explanatory principle. Purpose. If you saw a row of stones leading over the hill you would not be satisfied by the theory that they had got there by the law of gravity, but you would be satisfied if told they had been put there to mark the track. Religion, in a perfectly scientific manner, makes the hypothesis that this principle can be applied to the universe. It must be the purpose of a "Will" with power to carry out its purpose, *i.e.*, God. Religion makes this hypothesis. Faith is the process of verifying it. In religion you accept many things on authority. So you do in Science. I accept the theory that the earth moves round the sun, though my senses tell me that the reverse is the case. At this point it is not unreasonable for science to become agnostic and refuse to enquire further. But it is worth while applying the principle of purpose even though you cannot apply scientific proof. After all, the moral value of a religion lies in its uncertainty. It is a fine thing because it is an adventure. This value would disappear at once if it could be proved positively. The fact remains that all who have

honestly experimented in religion have become more and more convinced of its truth, although they cannot prove it to other men. All the men in the world who have done great things have been prepared to go beyond what they could intellectually comprehend. In this temper, then, we make the hypothesis of a Purpose in universe.

Then the question arises—What kind of Purpose? There can be no doubt that the Purpose of the world must be good. Religious experience always points to a good Purpose. Many elementary religions were nothing but sheer fright, but as they grew and evolved, the principle of a Goodwill behind the purpose of creation always appeared.

The great difficulty, the only scientific difficulty except the miraculous side of Christianity, is the problem of evil, a problem in which every religion except Christianity fails. Eastern religions give it up. The Buddhists do show a way out of sin. The Mohammedans say "All things are the will of Allah,' and the Confucians take no interest in sin. None of them explain it. Christianity finds the solution in the Cross. The principle involved is the winning round of the hearts that had inflicted the attack on Good personified in Jesus Christ. The only terms upon which God can forgive evil in man were by showing man what evil had cost Him. "It cost Me all that, but still I forgive." That is fundamental, and is the reason why Christianity is the only religion that can stand in a civilized world.

All that philosophy can say about the nature of the Purpose behind the world is that it explains the world. We once knew no more about it. Just as no one knows anything about Ether, except as Lord Salisbury said "It supplied a nominative to 'undulates,'" so it was with the original meaning of "Logos,' which was the Greek name for the principle that gives a rational explanation of the universe. St. John took that word and interpreted it "The Logos was made Flesh." That means that in Christ you have an intelligible expression of the supreme principle. But, if so, if God is like that, we can see what He is driving at. God made the world as the object of His Love. Evil got in—here no doubt is a mystery that needs treatment by itself—and spoilt His Purpose, the operation of Love. The *raison d'être* of the Church is to help His Purpose by practising it. It is as absurd to say you will not join the Church because you get no good *from it as it would be to have joined the army* to get good out of it. In both cases you join to help a purpose which you believe to be good.

Religion, then, consists in keeping in contact with God's Purpose by prayer, worship and communion, and in acting in accordance with it. That is what the Church is for. It exists to be the society or fellowship of those who, because they accept the dogma (or hypothesis) that the world is governed by a Purpose which is manifested in Christ, try to order their own lives and society as a whole in accordance with that purpose. The goal is the extermination of selfishness (which is the desire to gain rather than serve), and the universal reign of love (which is the desire to serve rather than to gain): and the reign of love is the Kingdom of God, because God is Love.

Guy's Hospital Physiological Society.

THE first meeting of the above Society for the Winter Session was held on November 7th. Dr. Pembrey very kindly took the chair.

The meeting first proceeded to business, and by a somewhat laborious but strictly up-to-date method of ballot the new secretary was elected.

Mr. Toussaint then read a paper on "The Physiological Aspects of the Higher Education of Women." The argument that intellect in parents tends to develop the size of the male child's head was not in agreement with the view that intellect was not hereditary. The higher death-rate in male children was due to the lack of care of the mother for her weaker offspring. The surplus of women in the world led to the necessity for their education in order to give them a fair chance of gaining a livelihood. In the case of the married woman, education was necessary to enable her to be a help and a stimulus to her husband and in order that she could, in case of accident or death, support herself and family.

The physiologist would do more service by refraining from the denunciation of education for women and by agitating for State Endowment of Motherhood to remove the material difficulties of supporting a family.

The speaker thought that nothing, not even higher education could destroy the maternal instinct. That modern women did not illustrate the natural laws of marriage was due to the despotism thereof. Men's chief reason against higher education for women was that, as with education comes knowledge, so the women with their newly acquired knowledge would insist on equal rights in marriage. Women's distaste for the unfair conditions of marriage and not lack of maternal instinct was the chief reason that these natural laws of marriage were not carried out at the present day.

Three drawings of female heads were then shown—one typified beauty, another intellect, and the third a combination of both attributes. Any normal

woman could satisfy the physiological needs of a wife, but to be a true mate, a helper and companion to the husband, intellect was a necessity.

The speaker closed with a quotation from the Physiologist's "Utopia," and the meeting was thrown open for debate.

The discussion that ensued did not develop the physiological aspects of the case to any great extent. The clashing of intellects in marriage was emphasized by one speaker, while another held that if true intellect is present in the wife, it will not obtrude itself upon the husband.

The principle of the physiological division of labour was cited as evidence against women's specializing in higher education, and examples were quoted from Varsity Honours lists. It was then pointed out that these examples were merely abnormalities.

Dr. Pembrey explained that though intellect was not hereditary, the stimulus of intellect in the parents would accentuate any variable characteristic such as the size of the male head, and he pointed out that resulting increase in size gave no indication as to the intellectual capacity of the child.

A few speakers waxed sentimentally reminiscent of "beautiful and intellectual damsels" they once had known. A suggestion was made that the artist had tried to bias the opinion of the house by not dressing all his figures in the same way; in defence the artist pleaded an attempt to avoid stereotyped work. A suggestion that the meeting be adjourned till ladies could be invited to state their views was abandoned owing to its difficulties, both social and physiological.

The meeting closed with a hearty vote of thanks to Mr. Toussaint for his paper and to Dr. Pembrey for taking the chair.

Change of Address.

T. R. Trounce, Hillview, High Street, Cheshunt, Herts.

S. W. Coffin, 30a, Wimpole Street, W. 1. (Tel. Mayfair 4117) (In addition to Golders Green address).

T. S. Keith, M.B., 11, Welbeck Street, W. (Tel. Mayfair 7069.)

R. Creasy, Jnr., 34, Bruton Street, Berkeley Square, W. (Tel. Mayfair 2986.)

J. A. B Hammond, 9, Cleveland Gardens, Hyde Park, W. 2. (Tel. Padd. 150.)

C, Worster-Drought, 17, Harcourt House, Cavendish Square, W. 1.

C. H. Laver, 247, Woodstock Road, Oxford.

W. W. Leigh, Llansannor House, Cowbridge, Glam.

Geoffrey Dicks, St. Leger, Sandown, I.W.

R. P. Marshall, late Capt. R.A.M.C., 26, Crooms Hill, Greenwich, S.E. 10.

P. C. P. Ingram, 36, Brynglwyn Road, Newport, Mon.

Capt. C. Dean, R.A.M.C., 36th C.C.S., Army of the Rhine.

Capt W. L. E. Reynolds, Officers' Mess, Royal Herbert Hospital, Woolwich.

W. Kelsey Fry, 24, St. Thomas's Street, S.E. 1.

On Research Work.

ONE good effect of the war has been the enforced realisation by the Government and the general public of the tremendous importance of scientific research.

At the present time there is a wave of enthusiasm in favour of promoting and encouraging research, which is accentuated in our own profession, and very markedly in this hospital. Although this movement is altogether desirable, it presents certain dangers, inasmuch as it is largely supported by individuals who have little direct knowledge of scientific methods and values, however praiseworthy their efforts may be. Such are inclined to regard the earnest study of a series of microscope slides, test tubes, or statistics as necessarily productive of valuable material.

We must recognise, however, that very few are qualified to pronounce an opinion and draw deductions from these observations: each requires a very highly specialised training and degree of knowledge. To set the seal of a responsible authority on the pseudo-scientific productions of an amateur, and possibly to guarantee faulty workmanship, is a very grave menace to progress.

A further source of danger lies in the potential wastage of time and energy, which, in these days, are more than usually valuable. Scientific knowledge is, generally speaking, far in advance of its practical application. The scientist himself, unless he keeps thoroughly in touch with the literature, British and foreign, on any particular subject, will rarely suggest a line of research that has not previously been investigated. Much less is the purely practical man likely to hit upon an unexplored channel. Occasionally, it is true, good luck and genius have enabled him to penetrate new regions with far reaching results; but, as a rule, to plunge into active research without a complete preliminary survey of existing records proclaims a man a dabbler—or an advertiser. Successful advertising and congenial dabbling are only justifiable pursuits if recognised as such, and not paraded as the genuine article.

This is not written with the object of discouraging seekers after the truth—far from it. Yet one would strike a note of warning against these possible dangers of unconscious intellectual dishonesty and the dissipation of precious energy by the needless repetition of exacting labour.

For the vast majority of progressive thinkers there is a far more fruitful field in the collection, consideration, presentation, and application of scientific facts elicited by experts than there is in rushing to print their own uncontrolled data and deductions. With all due credit to the various original observers, he who can gather and review the factors from every reliable source is the more likely to solve the wider problems: and therein lies the greatest triumph.

MEHTA.

"Mind and its Disorders."

By Dr. W. H. B. STODDART.

In his preface to this, the third edition of his work on "Mind and its Disorders," Dr. Stoddart states that his attitude towards mental disease has fundamentally changed since the last edition was published. This he ascribes to his investigation into the "psychology of the unconscious" according to the psycho-analytical method of Freud. The result is that a useful, if somewhat dull, students' text-book has been converted into a jumble of ill-digested psychology with inaccurate clinical descriptions, which may, perhaps, be regarded as a remarkable addition to pornographic literature, but can only lead the serious student of medicine hopelessly astray. Dr. Stoddart is an Examiner in Psychology and Mental Disease to the University of London. If he expects his examinees to give answers in accordance with his teaching we can only hope for their sake and for the reputation of the University that every candidate during Dr. Stoddart's tenure of office will have the honour of being ploughed.

According to Dr. Stoddart "neurasthenia is always due to partially or completely repressed auto-eroticism," whatever that may mean, and that it "quite commonly dates from the renunciation of masturbation." One can imagine the effect of the advice which must follow from this mischievous and utterly unfounded view. "Your symptoms," says the disciple of Dr. Stoddart to his neurasthenic war-pensioner, "are not due, as you thought, to the mental and physical strain of active service, the infections from which you suffered and the hardships you underwent. They are due to giving up masturbation. It was a great mistake to give it up when you were ten years old. Go home and masturbate again, my dear fellow, and then let me psycho-analyse you." That Dr. Stoddart's treatment must consist of this kind of thing can be the only possible explanation of his extraordinary statement that the symptoms generally return and that the patient "is often obliged in the end to seek permanent relief in an asylum." It is a relief, however, to hear from Dr. Stoddart that "most neurasthenics cannot afford his mode of treatment."

Under the head of diagnosis the author points out how frequently neurasthenia is wrongly diagnosed, doubtless owing to "inaccurate description of the disease." But what could be more inaccurate than his own description, in which he says "the appetite is good," "sleep is, as a rule, fairly good," and "examination with the perimeter soon fatigues the retina and, unless carried out quickly, the visual field will be found contracted"? Anorexia and insomnia are two of the most constant symptoms of neurasthenia, and it has been conclusively proved that the narrow field is always due to suggestion and that no such fatigue ever occurs if the examination is properly carried out.

Dr. Stoddart's views concerning the anxiety neurosis, by which he means psychasthenia, are equally startling and equally devoid of foundation. The condition, he says, is due to "sexual stimulation without gratification."

We can only offer our condolence to the students of the Medical School where Dr. Stoddart is Lecturer in Mental Diseases, when we find that we have to listen to such stuff as the following extract from the section on the etiology of exophthalmic goitre: "the usual sequence of events appears to be: (1) a fright, worry or anxiety induced by some incident or circumstance which symbolises sexual aggression; (2) partial or complete repression of the incident or circumstances, whereby the fear is left unattached . . . ; (3) partial or complete repression of the fear, which then finds expression in the symptoms of exophthalmic goitre."

The author finds much to commend in the old name of "hysteria." "The hysterical symptom is not due," he says, "to the presence of the uterus in the affected part, but it *is* due to a conscious refusal to give the *sexual instinct* its *proper place*, with the result that some non-sexual part of the body symbolically acquires a sexual valuation." After reading such views on the etiology of hysteria we feel only mildly surprised when we are told that the anæsthesia is usually on the left side "because the unconscious confuses right and left with right and wrong," and that the globus hystericus may symbolise to the patient "I have to swallow that," "that" being an insult!

The "unconscious" of Dr. Stoddart appears to be a wily sort of devil, which possesses his hysterical patients, for the sounder the advice he gives the more strongly it resists, "for the unconscious knows well enough when it has met a real enemy." It is a pleasant picture

to contemplate Dr. Stoddart, the modern crusader, battling with his psycho-analysis against the wicked "unconscious." But these fights take "an enormous amount of time, so that no physician can afford to treat a patient by this method without more or less proportionate" (presumably "enormous") "remuneration." As the only correct treatment for hysteria, neurasthenia and psychasthenia is, according to the author, psycho-analysis, and as "the shortest cases take an hour a day for three months, and some take an hour a day for three years," one can only exclaim "Lucky psycho-analyst!" though we might add "Unlucky patient!" Can Dr. Stoddart seriously mean that he could not cure any of the hysterical cases, which we are daily seeing cured in the wards and Out-Patient Department often at a single sitting (as, for example, cases of hysterical aphonia) and generally in a few days, in less than ninety hours of active treatment?

Dr. Stoddart's description of the symptoms of hysteria is as antiquated and inaccurate as his description of neurasthenia. We should like to know whether he has really seen an hysterical fit in which the patient "rests on the soles of the feet and top of the head." He appears to be unaware of Babinski's teaching, now universally accepted, that the physical stigmata are always the result of the unconscious suggestion of the observer, and he repeats the old fallacy that "the pharyngeal reflex is absent in hysterical aphonia, thus rendering laryngoscopic examination easy."

It is unnecessary to make further quotations, though the character of Dr. Stoddart's teaching is seen by the remark that "morphinism is always in part due to homosexuality, and that the best treatment of general paralysis is to give the patient hexamine and a plentiful supply of alcohol!"

Once again our condolences to the unfortunate students who are forced to listen to the author's lectures.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—The other day I happened to read in the "Gazette" of June 28th, 1919, which I had failed to open before, some remarks on the future of Clinical Ward. You said that "Clinical of the future might well be devoted entirely or almost entirely to medical research rather than to the diagnosis of difficult and acute cases."

If this should happen the appointment of "Clinical" would be completely altered if not abolished.

Since leaving Guy's I have met many men, from many hospitals, and of many nationalities, but I know of no school which offers its students an appointment comparable in value to that of Clinical.

I do not wish for one moment to decry the value of medical research nor of any of the special "ologies" which so markedly distinguish the medicine of to-day from that of 30 years ago. They are essential and must be encouraged, but since at least 90 per cent. of us earn our living by treating sick people, clinical medicine and surgery must remain, in my opinion, of first importance in the teaching of all medical schools.

The old tradition of Guy's is to turn out practical men; men who have handled a knife, who have borne responsibility, and who have learnt to make up their minds for themselves.

These things cannot be learnt in the class room, nor from books. They can only be learnt by actual contact with patients when no one is by to tell you what to observe and what to conclude from it.

To be a good clinician one must know the theory of one's subject, just as to be a good general one must have studied the art of war. But theory alone is insufficient, and practice is the only thing that makes perfect.

The appointment of Clinical gives a man his first real insight into the practice of medicine. Fresh from the spoon-feeding of the class-room and the wards he finds himself faced with the raw material of his trade. He does not know whether the House Physician who has carelessly told him to have a look at a patient on a stretcher is trying to palm off an undesirable chronic on him or bluff him that a rare case is of no particular interest. But he does know that whatever mistake he makes will be pointed out to him by his five colleagues, who will not fail to impress their opinion on him with lucidity and frankness.

In Clinical Ward, moreover, he has patients of his own, whom he can treat himself, and over whom he holds consultations with his chief, much as he will do when as a general practitioner he calls in a "second opinion."

Not until he gets a house appointment will he have such an opportunity of becoming a practical man, and I am convinced that all his life he will look back on the three months spent in Clinical as one of the most instructive periods of his professional career.

While I hope that Guy's will always be in the van as a teaching school and will always lead along new paths of knowledge, I trust that she will ever be able to boast that the student who enters her school may, if he shows sufficient ability and diligence, enjoy an opportunity of learning his trade such as no other school can offer him.—I am, yours truly, ARTHUR J. CLEVELAND.

Norwich.

October 28th, 1919.

Specialities.

A Useful Book of Samples.

We have received from Messrs. J. G. Ingram & Son, Ltd., of the London India Rubber Works, Hackney Wick, E., 9, a neat little book containing specimens of their "Satinette" Rubber Bed Sheetings. To handle and examine samples of the actual goods is always more convincing than a written description, and in the present case one cannot help being convinced of the high quality of the materials used and the wide range of sheetings available—suitable apparently for every conceivable purpose for which such sheetings would be required. Buyers at Hospitals, Infirmaries, and other institutions where considerable quantities of Rubber Bed Sheetings are used, cannot do better than obtain a copy of this little book, which should prove of great assistance to them in selecting the colour, thickness and substance of sheetings desired for various purposes. The Sheetings are all impervious to acid, alkali and ether, and are guaranteed not to peel, crack, harden or discolour. They are easily cleaned, and may be sterilised by boiling without injuring the fabric.

A Reconstructed Rhyme.

The Englishman said "It's a hedgehog,"
The Scotchman he said "Nay,"
The Irishman said "It's a pin-cushion
With the pins stuck in the wrong way."

—Nursery Rhyme.

Sir Cooper said "Sarcoma,"
Dr. Fawcett he said "Nay,"
Dr. Laidlaw said "It might be,
But the cells don't grow the right way."
Mr. Hughes suggested Leprosy,
Dr. Barber Syphilide,
But the patient, (Oh, how commonplace!)
Simply went and died!

University of London Military Education Committee.

The Secretary submits with a view to publication the following note on arrangements for the teaching of Military Science in the University:—

TEACHING OF MILITARY SCIENCE.

The academic teaching of Military Science as a subject of curricula for degrees of the University of London which has been suspended during the war is to be resumed in the University in the Session now opening. Some years before the War Military Science was introduced as an optional subject for the Intermediate and Final Courses for the B.A. and B.Sc. degrees. The syllabuses have recently been revised by the Senate in the light of experience gained during the War and it is expected that, in view of the large number of students who have gained practical military experience during the War, the subject will attract an increased number of students. The subject can be studied in the University both as a branch of general education and, in the case of candidates for University commissions in the Regular Army, as a preparation for their profession. Both classes of student will be able to obtain practical miitary training in the University Contingent of the Officers Training Corps. The post-war conditions under which commissions in the Regular Army may be obtained by University candidates have not yet been published. Before the War these commissions were available for University of London students but owing mainly to economic conditions only a small number of students were able to qualify. The increased pay now offered to Regular officers should attract to the Army a larger number of students of the University. The number of commissioned officers of the Army, Navy and Air Force who served in the War after receiving training as cadets in the University of London O.T.C. is 4133. These officers have gained 1443 distinctions, including V.C., 5; D.S.O., 40 (5 with a Bar); M.C., 524 (3 with two Bars and 48 with one Bar); and 630 have fallen in the War. Judging from these results, there is every reason to hope that the University will be able to make a useful contribution to the commissioned ranks of the Regular Army. Major G. P. A. Phillips, O.B.E., has been appointed lecturer in Military Science for the current Session. Lectures and practical training will be arranged at centres in London convenient for the students of the various Colleges who desire to study the subject. The University examiner in Military Science both for Internal and External students is Col. Maxwell Earle, C.M.G., D.S.O.

46, Russell Square, W.C.1.

3rd October, 1919.

Notices.

University of London.

KEDDEY FLETCHER-WARR STUDENTSHIPS.

The Senate invite applications for the Keddey Fletcher-Warr Studentships for the promotion of post-graduate research. The Studentships, which are

tenable for three years and are of the annual value of not less than £200, are open equally to men and women of European descent who are graduates of some British University, or have passed an examination necessary to qualify for a Degree of some British University, but other things being equal, preference will be given to a graduate of the University of London. Applications must be received not later than 31st December, 1919. Further details can be obtained on application to the Academic Registrar, University of London, South Kensington, S.W., 17.

3rd November, 1919.

Examining Board in England by the Royal Colleges of Physicians of London and Surgeons of England.

The following are the dates on which the Examinations will commence for the year 1920:—

FIRST EXAMINATION.

*Chemistry and Physics—Tuesdays, January 6th; March 23rd; July 20th; September 28th. Biology—Wednesdays, January 7th; March 24th; July 21st; September 29th. Practical Pharmacy—Thursdays, January 15th; April 8th.

SECOND EXAMINATION.

Part 1. Physiology—Thursday, January 1; Friday, March 26th; Thursday, June 24th; Friday, October 1st. Anatomy—Friday, January 2nd; Thursday, March 25th; Friday, June 25th; Thursday, September 30th.

Part 2. Materia Medica and Pharmacology—Mondays—June 28th; October 4th.

THIRD OR FINAL EXAMINATION.

Medicine (1st paper)—Tuesdays, January 13th; April 6th; July 6th; October 12th. Medicine (2nd paper)—Wednesdays, January 14th; April 7th; July 7th; October 13th. Midwifery—Thursdays, January 15th; April 8th; July 8th; October 14th. Surgery—Fridays, January 16th; April 9th; July 9th; October 15th. (Practical Pharmacy—See First Examination).

*The examination in Practical Chemistry will be held on Fridays, January 9th, March 26th, July 23rd, October 1st.

Candidates intending to present themselves for Examination are required to give notice in writing to the Secretary of the Examining Board in England, Examination Hall, 8-11, Queen Square, Bloomsbury, London, W.C., 1, *fourteen clear days before the day on which the Examination commences*, transmitting at the same time the required Certificates.

All Candidates are required to produce Certificates of Age when entering for the first time for any part of the Final Examination.

All Fees must be paid not less than three days prior to the day on which the Examination commences.

Synopses indicating the range of Subjects in the Examinations in Chemistry, Physics, Elementary Biology, Practical Pharmacy, Physiology, Materia Medica and Pharmacology, Forensic Medicine, and Public Health may be obtained together with the Regulations.

NOTICE TO UNIVERSITY CANDIDATES.

Candidates are reminded that they should send with the Schedule of Certificates when applying for admission to the Final Examination, a certificate from the Registrar or other official of the University showing that they have passed Examinations in the subjects of the earlier Examinations of the Board.

N.B.—Books of Questions set at the several Examinations of the Board for each year from 1887 to 1919 may be had on application to Messrs. Taylor and Francis, Printers, Red Lion Court, Fleet Street, London, E.C., 4. Price 6d. each, Post-free 7d.

FREDERICK G. HALLETT,
Secretary.

Reviews, etc.

First Lines in Dispensing.—by E. W. Lucas and H. B. Stevens (Price 6s.).

This text-book, written "primarily for students, nurses, and others," can be usefully studied by those people of riper experience who occasionally require a little assistance with their dispensing problems. Commencing with suggestions as to the outfit of the dispensing bench, chapters follow explaining pharmaceutical operations, and dispensing methods. We notice especially the sections on weights and measures, percentage solutions, and the table of solubilities showing "grains in one fluid ounce of water." The instructions for dispensing are clearly and concisely stated, and should give good results. The type is good and the illustrations distinct.

Electro Diagnosis in War.—Zimmern and Perol. Edited by E. P. Cumberbatch. University of London Press (7s. 6d. net.).

Dr. Cumberbatch has translated Mm. Zimmern and Perol's book on "Electro-Diagnosis of War" for the Military Medical Manuals series. As a matter of fact, no more practical or better account of muscle testing exists, and it is to be hoped that its title will not prevent its use in civil medical work. The surgeon will naturally turn to the Author's conclusion as to the diagnosis of a divided nerve, and will be disappointed to find that no definite evidence can be obtained at one examination. At the same time, they show very clearly the importance of repeated examinations in doubtful cases, and the weight to be attached to the evidence obtained. There are excellent accounts of chronaxic and condenser testing, and a very useful chapter on the use of electro-diagnosis to medical boards. Considering the excellence of the book in other respects, we are surprised that the illustrations, which are for the most part original and are decidedly useful, should have been so indifferently reproduced.

Football.

GUY'S v. LONDON IRISH.

It was a splendid afternoon for football on Saturday, October 11th. Little wind, a low temperature and good going. The ground might have been softer, but no one was too heavily flung. Marais got one on the head in the second half, but this was more from leather than from earth.

The Hospital won by 6 goals, 3 tries, 39 to nil. The team was not quite at full strength, because J. Krige was away. Schollum also gave way to Woodruffe. The game opened late, the ground being a long way from town and difficult to find. It was an Irish player who was late; the breakdown on the District detained him, his side had, therefore, to start with 14 men. Guy's took a few minutes to settle down. Steyn on the right and Woodruffe on the left failed to accept; then came Van Schalkwijk with a neat effort that opened the scoring. Steyn kicked a good goal from a nasty angle, and promptly converted two sitters subsequently from tries gained by Shellswell and himself. The forwards were doing remarkably well at this stage, though the concerted effort in the rushes is still wanting. There is not sufficient backing up yet; it will come, and a very fine pack will result, especially if all push a bit harder, and one who takes it easy in the scrums puts his heavy weight in with all his might. Shaw got a try behind the posts, and Bekker wriggled through in the way he specialises in. Neither of these tries were added to, so that at half-time Guy's led by 22 points.

After the resumption Guy's went ahead, and a very high score looked certain. Watson, Krige, Steyn and Van Schalkwijk gained tries in quick succession, the last-named being very prettily accomplished.

The South African's hands are very safe, and the only possible criticism one could venture on his game is the momentary hesitation before passing the ball. It steadies him, but the receiver is apt to over-run the pass. One kick at goal was excellent, that by Crook, the other two conversions were easier. Doherty led his men splendidly. The finish was not very exciting, as Guy's slowed up somewhat, so much so that once or twice the Irish got close up. The tackling of our opponents was weak; up against a stronger side doubtless tactics will differ. But it is always difficult to keep going at concert pitch when the opposition is not strong enough to fully extend. The Irish full back had lots to do, and he attempted all that was possible. It was not his fault the score was so high. Those in front of him seldom brought off a firm hold. Final score: Guy's, 6 goals, 3 tries, 39; London Irish, nil. Guy's team—W. Olivier, G. L. Steyn, F. Krige, T. A. Shaw, B. C. Woodruff, F. Bekker, J. Van Schalkwijk, W. D. Doherty, F. W. Reitz, F. W. Crook, A. H. Shellswell, C. F. Marais, E. Neser, L. K. Watson, E. Pauw.

GUY'S v. ROSSLYN PARK.

This match was played in a biting wind at Richmond on Saturday, October 25th. Bekker was away from the scrum base, and the outside left position was taken by Van Nickert. It is hoped that soon an old and distinguished Guy's player will take his place here, and lucky he will be to have Graham Davies as a partner.

Rosslyn Park forwards put up a very strong game during the first half, but they were very frequently offside and allowed to go on unchecked. On the other hand, our own pack were kept very strictly to the whistle. Once Reitz purposely held himself back for Shellswell to put him onside, but as soon as Shellswell came up the Referee whistled for a scrum back. An extraordinary decision also was given when Millett was about to kick at goal after Steyn's first try, a magnificent effort on the wing player's part. The referee allowed Rosslyn Park to charge apparently before the ball was grounded, and when all hesitated told the players to proceed, with the result that Shellswell almost immediately went in for a second try. Doherty was nearly in just after, but had not sufficient pace to get quite to the line. Fine passing by the three-quarters led to Steyn crossing the line again before half-time, and Millett placed a neat goal.

Almost immediately on resuming Guy's went further ahead, Steyn being again the scorer. The passing reached him well down field, and his great pace did the rest. Millett landed a very fine goal. The ball was not handled from now on with quite the necessary snap, though Davies put in some fine runs and Meacock did sterling work. The next score came from the forwards. Going with plenty of dash for the line, Shellswell secured and raced right behind; again Millett goaled. Then came a fine try, the best of the match; all participated, the forwards pushed the Park clear of the ball, the halves and three's all handled, Van Nickert got the try, and Millett made a good but unsuccessful shot at goal. Again Steyn came along at top pace, but, faced by two opponents, he passed back to Krige, who was marked and at once tackled. Had Steyn gone on, feinted or swerved, he would have done better. The team did well indeed, but their work was not quite so polished as usual. Probably they felt the adverse decisions were a little disconcerting. The forwards were great, both halves and three-quarters very good. But one would like to see Van Schalkwijk get more steam up, and much of the passing would prove more valuable if opponents were drawn before parting with the ball. Millet was splendid, and no mistake was apparent. Doherty, Reitz and Shellswell gave a great display. Final score: Guy's, 3 goals, 3 tries, 24; Rosslyn Park, nil. Guy's team—H. Millett, G. L. Steyn, J. Krige, Graham Davies, G. Van Nickert, G. R. Meacock, G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, A. H. Shellswell, G. R. Aspinwall, L. K. Watson, A. Marais, E. Neser, G. Zondagh.

GUY'S v. OLD BLUES.

It is a strange but certain fact that the Hospital forwards take a little time to settle into their stride. As at Richmond on the previous Saturday, and again at Honor Oak Park for the above match on November 1st, the game once in full swing they played much better and no fault could be found. Criticism from a comfortable seat in the covered stand is very easy, but the looker-on sees most of the game, and at first the pack was slow and not half smart enough on the ball. Doherty was missed, and the newcomers took time. During this early off period the Old Blues were dangerous on several occasions, and one would like to see out defence more thorough. Stop these attacks in mid-field, do not let play reach Millett. Meacock, Davies and Krige showed sound defence. So did Millett. He never failed to clear, and splendid was his display. Davies and Krige scored during the first portion of the game. Davies has fine imagination; he is always on to the slightest chance, and had hard luck in not getting in again. Krige took a pass at top speed, and Davies was almost over. Reitz also made a good attempt, and ends were changed with a 6 points lead.

Resuming, Shellswell again played grandly, but several times the opposition broke away menacingly. Then good forward work with Reitz ever in the front ended in that sterling forward getting over for Millett to goal. Cleverly Meacock sold the opposition, and got right up to the line for Van Zijl to get the next try; this time Millett's kick, finely judged, hit the upright and fell the right side. Reitz led several more rushes. Marais helped him and so did Duncan and Neser, the last-named getting over for an unconverted try. Passing went to the left, and much high kicking was indulged in, but it was overdone. Steyn had few chances for this reason, and another factor was the fine full-back play of Chamberlain of the Old Blues. His tackling and general play roused much enthusiasm. The way he tackled Krige when the three-quarter was going full speed for the line was a glorious example of fearless defence. Before the final whistle Reitz literally ploughed over for a final try. It looked as though Krige gave him a gentle heave to make sure. Millett did the needful, and Guy's were left victorious with 3 goals, 3 tries, 24 points to nil. Davies played in top form all through. Van Nickert cannot help not being quite fast enough to keep up with him, but he tried very hard; a little more pace, and he would be most valuable. Guy's team —H. Millett, G. L. Steyn, J. Krige, H. Graham Davies, J. Van Nickert, S. P. Meacock, G. Van Schalkwijk, F. W. Reitz, A. H. Shellswell, A. F. Marais, L. K. Watson, E. Neser, G. Zondagh, B. F. H. Duncan, H. Van Zijl.

"A" TEAM v. CHRIST'S HOSPITAL.

A very good game at Horsham on October 25th resulted in a win for Guy's by 2 goals to a try. The school, though outweighed and outpaced, played a hard and plucky game. The only score in the first half was a try by Williams as the result of a good three-quarter movement.

The school started off with a rush after half-time, and from a line-out close to our line one of their forwards got over. Guy's then pressed for some time, and eventually scored through some good play by the forwards, Laver touching down. Daneel converted on each occasion. During the last ten minutes Guy's were very hard pressed, but no further score resulted. The team consisted of—Olivier, Daneel, Shaw, Seward, Williams, Levisseur, Lloyd, Van Zijl, Laver, Biddle, Helder, Duncan, Bradfield, Currie, DuToit.

"A" TEAM v. OLD BLUES "A."

Owing to the greasy state of the ground, this game at Ravensbourne on November 1st consisted mainly of forward play. The Guy's pack dominated the game throughout, and in the first half tries were gained by Biddle and Seward, the last-named player running through cleverly. The score at half-time was 10-3.

In the second half also play was of a very scrambling nature, accurate handling being almost impossible. Any attempts at passing failed badly. The only try of the half was scored by Williams. Daneel converted all three tries. Result—Guy's 15 points; Old Blues, 3 points. Team—Olivier, Williams, Seward, Shaw, Mackenzie, Levisseur, Daneel, Biddle, Laver, Helder, Bradfield, Currie, Chambers, Hibbens, and Parsons.

October 11th—Guy's "A," 11 points; R. M. A., Woolwich, 33 points.

October 18th—Guy's "A," 78 points; Old Alleynians, 0.

Golf.

Under ideal weather and ground conditions the Hospital played a friendly match against St. Thomas's, which resulted in an easy win for Guy's by five matches in Singles, one being halved, and two in Foursomes, one being halved. Guy's scoring $8\frac{3}{4}$ points, St. Thomas's scoring $1\frac{1}{2}$ points.

SINGLES.

GUY'S.		THOMAS'S.	
A. C. M. Coxon (4 & 2)	1	A. R. Walker	0
O. G. Morgan (3 & 2) ...	1	S. H. G. Humfrey ...	0
G. M. Stuart (4 & 3) ...	$1\frac{1}{4}$	H. W. Briggs	0
K. F. McAlpine (halved)	$\frac{1}{2}$	J. L. Farquharson ...	$\frac{1}{2}$
C. Gill Carey (4 & 2) ...	$1\frac{1}{4}$	A. J. Smart	0
A. R. Crowe (3 & 1) ...	$1\frac{1}{4}$	J. Hale...	0
	$6\frac{1}{4}$		$\frac{1}{2}$

FOURSOMES.

A. C. M. Coxon and O. G. Morgan (3 & 2) ...	1	A. R. Walker and S. H. G. Humfrey... ...	$\frac{1}{2}$
G. M. Stuart and K. F. McAlpine (halved) ..	$\frac{1}{2}$	H. W. Briggs and J. L. Farquharson ...	$\frac{1}{2}$
C. Gill Carey and A. R. Crowe (3 & 1)	1	A. J. Smart and J. Hale	$\frac{1}{4}$
	$2\frac{1}{2}$		1

Birth.

LONG.—On Nov. 6th, at Chedworth, Orleans Road, Hornsey Lane, Highgate, N., to Violet (née Hook), wife of Dr. Harold O. Long—a son.

SPICER.—The wife of Dr. Arthur Spicer, M.C., of 6, Seymour Street, Portman Square—a daughter.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

VOL. XXXIII., No. 819.] NOVEMBER 29, 1919. [SIXPENCE.

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Sir COOPER PERRY, M.A., M.D., F.R.C.P.

AT the meeting of the Senate of the University of London on Wednesday, Nov. 19th, Sir Cooper Perry was appointed, we believe by a unanimous vote, Principal Officer of the University of London. As this is a whole-time appointment, Sir Cooper's acceptance of it will entail his resignation from the post of Superintendent of Guy's Hospital.

Two thoughts arise in our mind in connection with this announcement: one, that the University of London is fortunate in retaining in this new capacity the services of so distinguished an administrator, for as Principal Officer Sir Cooper will to a great extent carry on the work which, as Vice-Chancellor, during the War, when the post of Principal was in abeyance, he did to the extreme satisfaction of all parties in the Senate; the other, more poignant, thought is that Guy's Hospital will lose, in the person of its Superintendent, one who has been a figure-head for the last 27 years, that Guy's without Sir Cooper will be, to many generations of Guy's men, a place almost unthinkable.

This is not the occasion to give any detailed account of Sir Cooper's work at Guy's since 1892. 'Si monumentum requiris, circumspice.' We hope he will be with us for many years longer in some other capacity; but all who have worked under the 'Super.' in the last 27 years will remember with affection, in addition to his great intellectual powers, his shy kindness, his justice, his breadth of sympathy, and his humanity. He sought no advertisement, but his advice was sought by men of all ages and interests, and no one went to him in vain. Such a combination of intellect, conscience, and heart is irreplaceable.

Passim.

THOSE who have not already heard it will learn with the deepest regret that Sir Cooper Perry, the "Super." as his friends affectionately term him, is leaving the Hospital on January 31st. He has just been unanimously appointed by the Senate, Principal Officer of the University of London, and takes up his duties there on February 1st. We can only bid him "God speed" in his new work, which we doubt not will be done with the same insight, ability, and humanity as have made his career at Guy's so great, and the position he is accepting is one which will offer wide scope for his administrative powers. But he will be sorely missed at Guy's, where his personality has been a "strong tower" and an inspiration to so many, and for the good of which he has unceasingly striven for more than 27 years. We are encouraged to hope, however, that we shall still have the benefit of his interest and help and shall not altogether lose him.

ON Tuesday, December 2nd, at 4.30 p.m., Mr. F. A. McKenzie, Chairman at the Essex Hall meeting, will give an address on "The Truth about Prohibition." Mr. Ormond has kindly consented to take the chair.

IT is good to hear the cheerful strains of the Niggers practising again in the College. In the wards, too, nurses may be seen sewing weird designs. These are unmistakable symptoms of Christmas-time. We wish them all, nurses and men, the best of luck in their efforts.

AT the request of an old Guy's man, we publish in this issue a list of the days and hours of attendance of the members of the Staff at Out-Patients. As matters stand at present, it is very common to see patients with letters addressed to a physician or surgeon who is not in the hospital on that particular day. It is hoped that this list will not only be useful to the general practitioner, but also save the patients from unnecessary waiting.

WE are pleased to see that the new constitution of the various firms at Guy's has been favourably spoken of by our American colleagues. In a recent issue of the "Journal of the American Medical Association," a very full account of the scheme was given. So far it has worked very well. The only criticism which one hears at all frequently is levelled against the abolition of the old appointment of Surgical Ward Clerk, which was doubtless a most useful appointment. However, the new Probationary Clinical Course should prove a most interesting and instructive three months, and it is certainly more rational in theory.

IN this number we publish the first part of Sir William Hale White's inaugural address to the Physical Society. In our next issue we hope to present to our readers a photograph of our famous and popular late Senior Physician.

IT has been proposed that a Students' Representative Council should be formed, the function of which would be to constitute an official means of communication between the students, on the one hand, and the staff and various committees at this hospital on the other. Many members of the staff have expressed the opinion that they like to have the men's ideas on various matters, and at present the only means of obtaining this information is by the unsatisfactory method of asking one or two individuals whom they happen to know. If such a Council came into being, it would send in recommendations on such matters as the educational curriculum, reconstruction, etc. Of course, these recommendations would, in many cases no doubt, be impracticable, but they would have the consideration of the various bodies composed of men of experience who have proved their administrative ability, and possibly some good ideas would be suggested. We hope that some such body will soon exist, as we believe it would be a source of satisfaction both to the student and to the teacher.

CONGRATULATIONS to Mr. Joffé on obtaining honours in Surgery and Pathology at the recent London Final. Also to Messrs. Laver, Widgery, Medlock, Lambrinudi, and Lane-Roberts on their recent success in the Primary Fellowship.

Two Cases of Abdominal Actinomycosis.

CLINICAL LECTURE BY DR. J. FAWCETT.

Oct. 29th, 1919.

GENTLEMEN,—I propose to bring before your notice to-day two cases of abdominal actinomycosis: the first a long-standing case in a woman who was admitted with an empyæma; later multiple abscess formations appeared beneath the diaphragm involving also the tissues of the abdominal wall. The primary cause was not discovered until the post-mortem examination was made.

The second case is of quite a different type, the patient presenting himself with an acute abdominal condition, of sudden onset, shortly leading to the formation of an abscess, which was opened. Examination of the pus from the abscess revealed the cause, as the "ray fungus" was discovered in it.

These are two interesting and instructive cases, and I propose to enter somewhat fully into the details of them.

CASE I.

A woman, æt. 29, was admitted, under my care, on October 8th, 1918, with pyrexia, and pain in the right side of the chest. In June of that year, she stated she had suffered from an attack of "influenza," of some three weeks' duration. A month later, while away at the seaside convalescing from her illness she experienced pain in the right side on stooping to pick up some object. This pain persisted, and recently had been getting worse. The patient also informed me that some time previous to admission she had been more ill, with severe pain in the abdomen on the right side, and I gathered that a doctor under whose care she was had diagnosed "appendicitis."

The patient had lost considerably in weight during her illness, and on admission she had a thin drawn face, flushed cheeks, and a moderately high temperature of the hectic type, as you may see from the charts which I will pass round.

Over the right side of the chest there were physical signs indicating the presence of a pleural effusion. On exploration, pus was found, and this was aspirated; and on October 13 the empyæma was opened and drained. I gather that at this time no physical signs of disease were found elsewhere, and that cultivations made from the pus were sterile.

Now here comes an important point: On October 17th the report from the Bacteriological Laboratory stated that direct examination of the pus was negative, nothing more than pus cells being present; no bacteria no other organisms, and no tubercle bacilli being detected.

What struck me most forcibly about the patient was that she looked exceedingly ill, that her temperature was consistently of the hectic type, and that the discharge from the empyæma was so very foul. Also, below the level of the diaphragm there was a sense of increased resistance on palpation, suggesting the possibility of mischief in that region. It looked as if there was some deeper-lying cause for her condition than the empyæma, which apparently was being drained satisfactorily.

The contingence of a previous appendicitis, in conjunction with the features mentioned above, made me contemplate the possibility of infection of the pleura from a focus below the diaphragm. The liver dulness was not increased, and this organ could not be felt, although over the hepatic area there was tenderness on palpation. There was no jaundice at any time.

On November 3rd an anæsthetic was administered in order to open a collection of pus which had appeared in the perinephric region. Cultivations from this pus also were sterile. The temperature continued to exhibit a swinging character as before.

Passing on over a period of two months, with the temperature chart showing the same daily variations as before, we reach January 29, 1919, and on this day a further abscess was discovered at the lower margin of the ribs, posteriorly, which had apparently burrowed from below outwards, the pus infiltrating the tissues of the abdominal wall. This abscess was opened, and on this occasion cultivations from the pus gave a growth of staphylococcus aureus, the bacillus of Friedlander, and a diphtheroid bacillus which implied that the abscess cavity had become infected with pyogenic organisms.

March 4th. The progress of the patient was still unsatisfactory, the up-and-down temperature persisted, and the physical signs suggested that another abscess was forming below the diaphragm. I asked Mr. Bromley to see the patient once more, and he opened a subphrenic abscess, higher up than the previous perinephric abscess. No direct connection could

be traced between the sub-phrenic abscess and the empyæma.

The wounds were draining well enough, but the patient dragged on, becoming gradually more wasted and weaker. After again consulting Mr. Bromley it was decided that further surgical intervention was inadvisable.

The patient gradually sank, and died on May 20th, 1919, about seven and a half months after entering the hospital.

I do not propose to go through again with you the various conditions discussed at the bedside in our attempt to arrive at a diagnosis. Suffice it to say, we thought that the primary seat of the disease was in the abdomen, and that the pleural infection was secondary to it; that the most likely cause was an "appendicitis" which had apparently become quiescent so far as local signs of its presence were concerned, but that nevertheless it was not "cured." This "latent" appendicitis was considered by us to be the focus from which an infection had spread with the resulting formation of a perinephric abscess, later of a subphrenic abscess and then of an empyæma by extension of inflammation through the pleura.

Autopsy.—We will now turn to Dr. J. A. Ryle's report on the autopsy.

The liver was found to be considerably enlarged, projecting a hand's breadth below the costal margin. The right lobe was adherent to the lower ribs and to the upper pole of the right kidney, over which was disseminated a layer of purulent lymph. The liver, as you can see, contains a single spherical abscess without any capsule, the size of a large orange, having a general striated or radiating appearance, and holding a cheesy material from which pus exuded. Floating in this pus were grey and yellow granules. The abscess communicated directly, Dr. Ryle states, with those which had been opened around the kidney and beneath the diaphragm. The infection had apparently spread through the diaphragm to the pleura.

The spleen, pancreas, suprarenals, kidneys, and all the other viscera were normal. The appendix was very long, and there was a complete stricture about an inch from its tip, with adhesions around it. The layers of the pleura were firmly adherent, and in the region of the empyæma on the right side the pleura was especially dense and thick; the drainage of the cavity was complete. On the left side there was a recent empyæma which contained six to eight ounces of sweet pus.

Scattered through the lungs were numerous small hard nodules, equal in size to a pea, and on section they were found to be caseating and to contain fluid pus.

A stained film from the pus in the liver abscess showed the "Ray fungus," with its characteristic filaments and granules, and on anaerobic culture a pure growth of the streptothrix actinomyces was obtained.

Sections of portions of the liver and of the lungs showed, microscopically, the actinomycotic fungus.

Thus, this patient's illness was due to an infection of the liver by the "Ray fungus," resulting in a liver abscess, followed by secondary abscesses outside that organ, and also giving rise to actinomycotic deposits in the lungs.

The point to which I wish now to draw your special attention is, that the ultimate cause escaped recognition until the post-mortem examination was made.

Cases of hepatic actinomycosis are notoriously often overlooked or unsuspected until an autopsy is performed. You will recollect that the pus was only examined directly on one occasion, and with a negative result. Should we have found the actinomycotic fungus in the pus if we had had it examined more often? I do not know that, even if we had done so, we should have been able to influence the course of the disease in this patient because she was so exceedingly ill from the day of her admission. However that may be, it serves me as a text that, inasmuch as we learn most from our mistakes, often those of omission rather than of commission, this case may make some of you more persistent in examinations of pus than we were, and so, perchance, lead you to a right diagnosis and afford you an opportunity of doing more for your patient, even though in such a case a successful result may not be obtained.

Now, to consider some special features of this case, and first its mode of origin.

It is generally believed that the actinomycotic fungus is conveyed to human beings in grain or other vegetable food, and that it makes its way into the tissues through some part of the alimentary canal. Sometimes it causes swellings in the mouth; sometimes it enters through the wall of the œsophagus or of the stomach, but probably the "appendix cæci" is the channel through which the abdomen is most commonly infected.

Inasmuch as the primary focus of infection may heal completely, it may be very difficult to trace a connection between the site of entry and the ultimate results as we see them in the form of an hepatic abscess, an empyæma, and so on. The connection between the appendix and liver regions is well recognised anatomically, either via the blood stream or by direct spread along the sub-peritoneal tissue to the liver.

I drew your attention to the fact that the "appendix" exhibited signs of old inflammation, and it is possible that it was the original seat of infection in this case. The failure to detect a connection between the original focus of infection and the abscess formation is common enough, because, as I said, the primary focus may heal. When the fungus gets out of the sub-mucous tissue of the gut, it sets up inflammation, usually leading ultimately to abscess formation and slowly progressive changes in the parts affected, with much proliferation of the connective tissue.

As a result of these inflammatory and proliferative changes, large massive formations may arise, for example, a firm, hard swelling in the right iliac fossa, a swelling in the abdominal wall, or an enlarged liver, with finally the development of an abscess in or around it, and, perchance, an empyæma as an additional development.

Ultimately infection by pyogenic organisms may occur, and then, perchance, a general infection of the blood stream, a pyæmia. Fortunately the abscesses in most cases become shut off from the general peritoneal cavity, and hence they may be treated with more or less success according to the type of case.

Dr. H. M. Stewart, in an article on "Abdominal Actinomycosis" (Guy's Hosp. Rep., vol. liv., 1897), drew special attention to an interesting feature in the history of some of these cases, namely, that there was often a period of good health in the course of the disease, a period during which the infection was "latent."

Our patient, you may recollect, was well enough at one time, about July—August, to go to the seaside and apparently enjoy her holiday. This "latent peroid" lasted until about the beginning of September. I think there is little doubt that the original illness, called "influenza," was of the same origin as that for which she was admitted to hospital in October. Remember, then, this "latent period."

The next feature is the long duration of the illness—seven and a half months in hospital, and some twelve months in all; that she had an up-and-down temperature throughout, accompanied by the development of multiple abscesses.

With regard to prognosis, it is very bad in the hepatic cases, because of the great obscurity of the signs of the disease. The case comes before us as an empyæma, or as a sub-phrenic abscess it may be, and in consequence it is often mistaken for a collection secondary to "appendicitis," or it is thought to be a tuberculous abscess dependent upon caries of the spine. The diagnosis can, of course, only be settled by finding the organisms and filaments in the pus, and hence do not forget to examine the exudate, not only bacteriologically, but also by direct examination, and do not be satisfied with one examination if there is any doubt in your mind of the cause.

Case II.

A man, aged 47, who stated that he had been quite healthy until the onset of his present illness. On the evening of June 14th last he developed sudden pain and stiffness in the abdomen; he took a glass of brandy to relieve it, but vomited it up while driving home in a taxi. Later in the evening the pain became so severe that he sent for a doctor. The pain was worse next morning, and was distributed all over the abdomen, but particularly on the right side; it took the form of recurrent attacks of severe colicky pain.

The patient was admitted, under my care, on the next day, June 15th. His temperature was 100·8°, and it varied thereafter between 100° and 101°; the respiration rate was 35 per minute; the pulse rate 100.

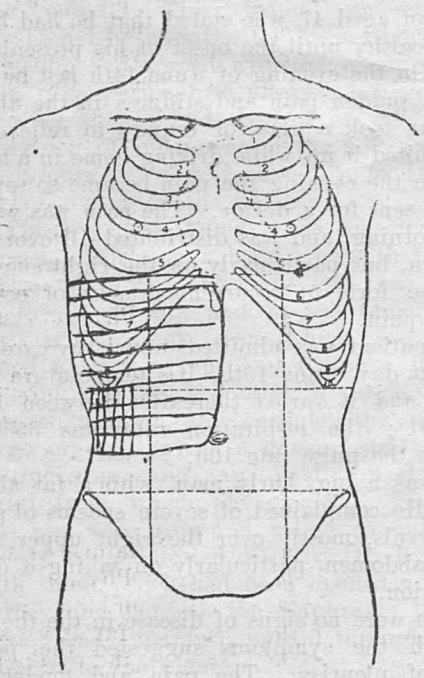
He was a big, burly man, with a fat abdomen. He complained of severe spasms of pain at intervals, mostly over the right upper half of the abdomen, particularly on taking a deep inspiration.

There were no signs of disease in the thorax, although the symptoms suggested the possibility of pleurisy. The pain and tenderness were distributed mainly over the situation depicted in the diagram by horizontal lines; and there was also some general increase of resistance over the same area.

No swelling could be detected in the right iliac fossa, in the loin, or in the gall bladder region. The liver dulness was normal, and there was no jaundice. There was no bile in the urine, but just a trace of albumen. The bowels were opened regularly.

The local condition remained much the same, and after four days the temperature gradually fell to about 99°. On the tenth day the temperature again rose to 102°, and remained high for a further four days. At the end of this period, that is, a fortnight after admission, the local signs of inflammation became rapidly more obvious, and a swelling was felt over the area marked by double crossed lines in the diagram, the swelling extending into the loin for a similar distance to that depicted in the diagram anteriorly. This swelling was obviously an abscess, and although we thought it had come forward from some part of the abdomen below the belly wall, yet it did not suggest an appendicular, perinephric, or subphrenic abscess.

I asked Mr. Turner to see the patient, and he opened the swelling and set free a large amount of pus, the abscess extending into the sub-peritoneal tissue.



Mr. Dowling, my house-physician, examined the pus the same evening, and found the "ray fungus" present. This was confirmed later by Professor Eyre, who reported finding streptothrix filaments, both on direct examination and on culture.

From that date onwards the patient did well, the temperature rapidly became normal, and early in August the patient returned home with the sinus nearly healed.

You see how different was the course of this case from the first; the first case was one of prolonged suppuration, with the formation of many abscesses; the second, an acute abdominal condition, developing into a localised abscess, which, after incision and drainage, and treatment by drugs, progressed very well. I want, however, to remind and impress upon you that the happy result was due to the fact that Mr. Dowling found the "actinomyces" in the pus, and so afforded the patient the chance of thorough and appropriate treatment by drugs after the abscess had been opened.

The importance of a routine direct examination of the pus from the abscess is emphasised because in an acute case, like this one, the possibility of an actinomycotic infection is scarcely likely to be thought of otherwise. If the examination had not been made it is quite possible that the case might have drifted on into one of prolonged suppuration and involvement of other organs with an outlook far less hopeful than we anticipate for our patient. No trace of actinomycotic fungus was found in the pus on July 23rd.

With regard to treatment, you may already know that these cases are influenced greatly for good by large doses of iodide of potassium. We increased rapidly the dosage in this patient until he was taking 45 grains of potassium iodide 3 times a day. In addition, the sinus was washed out with a solution of iodine. Mr. Turner did not think it wise to scrape out the abscess cavity on account of the loose tissue in which the abscess had developed. The patient was given also an autogenous vaccine made from the culture of the streptothrix. There is no doubt that many patients are greatly benefited and some are "cured" by the use of large doses of potassium iodide, up to two drams, ir ever more, a day if the patient can take it.

Progress was so satisfactory that other treatment, such as by X-rays, was not deemed necessary, although in some cases I gather that encouraging results have been obtained by this procedure.

Recently I wrote to the patient asking him how he was progressing. In his reply of October 23rd he states that he arrived home on August 3rd and at once placed himself under medical supervision, that he progressed favourably, and continued to take the iodide of potassium. On September 14th, when the wound was almost closed, the severe pain in the abdomen returned, and the patient writes that he

was reduced to much the same state as when admitted into Guy's. However, after four days of hot fomentations a discharge of pus occurred at the site of the old wound and he was completely relieved. He said that a sample of the pus exhibited on examination the presence of staphylococci, streptococci, and bacillus coli, but no actinomyces nor tubercle bacilli. The surgeon examined the patient last about the end of the first week in October, and was in every way satisfied with his progress, the wound being soundly healed once more. The patient was, I gather regarded as "cured."

Despite the favourable report in this letter I did not, perhaps, feel quite so happy about the patient as he was about himself, because, as I have told you previously, the "ray fungus" is apt to lie hidden for periods and then to break out again and give rise to further suppuration. Therefore, I have written to ask him to visit us again if possible.

Note.—November 10th, 1919. I have seen this patient to-day. The wound is soundly healed. There is no resistance, nor tenderness, nor any swelling to be felt in the abdomen, and no signs of disease to be discovered here or elsewhere. Examination of the fæces for streptothrix filaments was negative. Thus the prospect of a permanent cure is distinctly hopeful. We have advised a further six weeks' course of full doses of iodide of potassium and a repetition of the course after another interval of two months.

List of Days and Hours of Attendance of the Staff at Out-Patients.

Dr. Hunt, Mondays, 1.30.
Dr. Cameron, Wednesdays, 1.30 (medical), Mondays and Fridays, 10 a.m. (children).
Dr. Mutch, Thursdays, 1.30.
Dr. Poulton, Fridays, 1.30
Dr. Barber, Tuesdays, 1.30.
Mr. Turner, Mondays, 1.30.
Mr. Mullally, Tuesdays, 1.30.
Mr. Hughes, Wednesdays, 1.30.
Mr. Bromley, Thursdays, 1.30.
Mr. Slesinger, Fridays, 1.30.
Mr. Tanner, Saturdays, 1.30.
Mr. Chapple, Mondays, 1.30.
Mr. Bellingham Smith, Thursdays, 1.30.
Mr. Ormond, Mondays and Thursdays, 1.30.
Mr. Eason, Tuesdays and Fridays, 1.30.
Mr. Mollison, Tuesdays and Thursdays, 12 noon.
Mr. Layton, Wednesdays and Fridays, 12 noon.
Mr. Thompson, Wednesdays and Saturdays, 10 a.m.
Mr. Trethowan, Mondays, Wednesdays and Fridays, 1.30 p.m.
Dr. Barber and Mr. Mullally, (V.D.) Mondays and Thursdays, 6 p.m.
Miss Rawlins, (V.D. Females) Wednesdays, 1 p.m.
Professor Eyre, Tuesdays and Fridays, 9 a.m.

The Physical Society.

Being the Inaugural Address delivered before the Society, November 6th, 1919, by

SIR WILLIAM HALE-WHITE, K.B.E., M.D.

My first duty is to thank you warmly for having asked me to address you this evening. With the exception of a few months during which I was House Surgeon at the Evelina Hospital for Sick Children I have been at Guy's ever since leaving school, and am very glad, very fortunate, and very proud to have thus spent my life. Hundreds of men scattered about the world, and happily I am one of them, are devoted to Guy's, delight in having been educated at it, and love the very place and all its associations. Being thus permeated with affection for Guy's, you can understand what a real pleasure it is to find myself among you again, now that I am only one of the Consultants who are never consulted. The invitation your honorary secretary sent to me was accepted by return of post.

During the past five years those few of the students and Staff who remained at Guy's were so busy keeping the Hospital going as best they could, and working hard at many forms of war work outside, that the Physical Society, like many other Societies here, had to stop its meetings. Therefore, some of you probably hardly know what it is; if this is so, it will not be profitless to tell you something about it, and give you reasons why you should, for its sake and your own, try all you know to make its meetings successful.

There has been some uncertainty as to the date of the foundation of the Physical Society of Guy's Hospital, because, for the first few years of its life, there were, as far as we know, no minutes, but the stamp on the catalogue of its Library shows that it was born in 1771. Its name indicates that it was founded to study medicine, indeed, it is so stated in the preamble to its rules. We have in the Regius Professorships of Physic at Oxford and Cambridge and in the Physic Garden in Chelsea the same use of the word Physic which corresponds to the word Medicine now used to embrace medicine and its allied sciences. We call this a Medical School, meaning thereby that medicine, surgery, obstetrics, many specialities, chemistry, physics,

and biology so far as they relate to medicine, anatomy, physiology, pathology, and bacteriology are all taught here.

Guy's Hospital was opened on January 6th, 1725, beginning by receiving 60 patients. We know that by 1734, and probably earlier, pupils and dressers were attending the hospital practice. This is remarkable, and the energy of the Staff is further indicated by the fact that in 1771, that is to say, only 46 years after the first patients were received, the Physical Society, or, to give the full title, the Physical Society of Guy's Hospital, was founded. It was the first Medical Society in London of any importance; as far as is known there had been only two other small medical societies that have left nothing behind them and only existed a few years, but the Physical Society of Guy's Hospital existed as such till 1852, and is, as this, the Pupils' Physical Society, continued to the present time. The Medical Society of London, which still exists, was founded in 1773. About a quarter of its first Council were Guy's men.

St. Thomas's Hospital is extremely ancient, and for many centuries fronted on to the Borough High Street. In about 1215 it was re-founded. Like St. Bartholomew's, it was a religious institution for the lodgement of the aged and poor. Both these religious houses were spared by Henry VIIIth. By losses of property in the great fire its funds sank so low that subscriptions were invited, and to excite the Governors to subscribe, a list was published of those Governors who subscribed and those who did not. Guy later contributed large sums to building of wards at St. Thomas's Hospital, which was removed to its present site in 1871. You can still see parts of the old building behind St. Thomas's Church and above Mr. Grattan's book shop. Much of the ground on which it stood is now occupied by a parcel's post office.

Guy's original design was to have placed the hospital in which you now are, under the management of the Governors of St. Thomas's, but after he had begun the building of Guy's he decided to secure for it a management of its own. Hence there came to be two large hospitals on opposite sides of St. Thomas's Street, and the pupils of both attended the practice of both until 1836, and thus it is not surprising to find that the Staffs of both hospitals were original members of the Physical Society, although from its being called the Physical Society of Guy's Hospital, the desire to found it must have arisen in Guy's. Doctors living in the neighbourhood joined it, and many distinguished men living at a distance considered it a great honour to belong to it. The famous Dr. Lettsom was for a time president. The Society conferred the Diploma of Fellow on those who distinguished themselves by reading papers of exceptional ability, and Honorary Members were allowed to put S.H. (Socius honorarius) after their names.

The hospitals of Guy's and St. Thomas's being so close and so intertwined in their work were frequently called the United Hospitals, and there still exists a dining club called the United Hospitals' Club, membership of which is limited to those coming from Guy's or St. Thomas's.

That remarkable man, Mr. Harrison, the Treasurer of Guy's, who, born the year the Physical Society was founded, became Treasurer at the age of 26, always strongly supported the Society, and his support greatly contributed to its success. He held his office for 51 years. He was a most beneficent autocrat, and was known as King Harrison. His object in life was to make Guy's Hospital and Medical School famous, and he did everything he could to attain this end. The Charity Commissioners in 1837 reported that he ruled the Medical School and appointed physicians and surgeons at his discretion, but they added that his autocratic rule had been for the benefit of the Hospital and School.

Here I have the original book of the Laws of the Guy's Hospital Physical Society. The very advertisement inside it of the stationer from whom this well-bound book was bought is interesting, for it tells us that Henry Frome was not only a stationer, but he sold all sorts paper hangings in the greatest variety and newest patterns. Stationers do not at the present time usually sell wall papers. Let me read you the preamble to the Laws:—

"Certain gentlemen, desirous of improvement in medicine and other Sciences nearly allied to it, and convinced of the numerous and great advantages, arising from a free communication of observations and opinions, have determined for that purpose to enter into an association, which they chuse to distinguish by the name of the Physical Society. And perceiving, how much the attainment of the ad-

vantages which they expect from this Institution, may be facilitated by proper Rules, they have agreed to submit the following."

This is hardly capable of betterment; now as then, the object of your Society is improvement in medicine; now as then, we are convinced of the numerous and great advantages arising from a free communication of observations and opinions; now as then, we believe that medicine is a science. If you can, as you ought, make this Society continue to represent the convictions of the founders in 1771, you will carry on the good to medicine and to yourselves that they began just on 150 years ago.

The Physical Society in those days, as in these, meant business. Just listen to the fines:

1s. if five minutes late at a meeting.

10s. 6d. if a member did not read a dissertation when his turn came.

2s. 6d. if a President did not take the chair when he should.

1s. 6d. if a member leaves the room during a meeting.

6d. from everyone who comes to a meeting.

6d. a day for books kept out over a fortnight.

1s. from any committeeman who does not attend the committee to which he is appointed.

1s. from any member who refuses to serve on a committee.

1s. from any member who proposes to alter a rule, but fails to get the motion carried.

5s. for reading a paper different from that announced.

2s. 6d. for transgressing any rule.

10s. 6d. for taking from the Library the book containing list of papers to be read.

2d. for every hour an author is late in handing in his paper.

21s. if he does not hand in the paper at all before he reads it.

6s. if readers of papers change their dates.

5s. for not reading your own paper.

Presidents always to pay double fines.

The object of these fines was to provide money to buy books for the Physical Society Library. When the Society ceased in 1852, these books became part of the Library of the Medical School, now known as the Wills Library; they are still there and the original catalogue of them can be consulted. As much as £12 and £8 1s. was collected in fines at two meetings over 100 years ago. It has been stated that the Society "flourished on its fines." This is quite unfair. Its Library flourished on the fines, and a very good thing too. If you look through the minutes you will find the expenses of administration extraordinarily low; for example, we read that in 1782 it was resolved that the meetings be held in the Theatre of Guy's Hospital, and the porter of the hospital be rewarded for preparing the Theatre with candles. The Theatre was borrowed free of charge, so the expenses were candles. Five guineas were once given to a widow whose husband died of hydrophobia, but it is not stated why this was done. In a recent GAZETTE the extract from the letters of a London Medical Student, written in 1818, says he failed to get the Physical Society's Prize, and he understands that this was because the funds of the Society were so low. If this is a true suggestion, it is probable that the money had been spent on books.

The Society's meetings were held first at 6, then 6.30, and then at 7 p.m. Everything was earlier in those days than now; it will horrify you to learn that some lectures were at 7.30 or 8 a.m. Meetings were held weekly, and about thirty meetings constituted a session, thus you will see the Society did plenty of work.

It is obviously impossible to give an account of all the distinguished members of the Physical Society. Its earliest President was Dr. William Saunders, one of the physicians to Guy's Hospital. He was the first person to lecture at Guy's Hospital and he lectured on physiology, medicine, chemistry and materia medica. Probably his lectures were very popular, for Astley Cooper describes him as a very entertaining lecturer. He wrote a book on Diseases of the Liver which passed through several editions, and he founded our present knowledge of jaundice. Like many physicians of the time, he wrote on Peruvian bark. He was instrumental in founding the Royal Medico-Chirurgical Society, and therefore is the Father of the present Royal Society of Medicine. His weakness seems to have been passing other people's knowledge off as his own, a crime which has not yet ceased.

On looking through the old minutes of the Physical Society it appears that probably the four most active of the earlier members were

Astley Cooper, Babbington, Haighton, and Curry.

Astley Cooper's fame is known to all, and he may be said to be influencing us very materially even to-day, for Sir Harold Stiles in the inaugural lecture which he gave at Edinburgh this October mentions that he was attracted to surgery by his grandfather who owed much of his enthusiasm for it to Astley Cooper. He was a wonderful man, cheerful, good-looking, well-built, a good speaker, a born teacher. He had untiring industry, dissecting before breakfast, and yet visiting the wards late at night; he was a great surgeon, skilful as an operator. He enjoyed marvellous health, saying he could digest anything but sawdust. He was enthusiastically fond of his profession; even at the height of his fame he would step out of his house by a back door leaving a room full of private patients unseen in order that he might be punctual to meet the enormous crowds of students waiting to go round with him. Wags said his butler saw the patients he left behind; and finally, he had this great advantage that he knew his limitations: he was aware he was not a John Hunter, and so he did not pretend to have his mind.

Dr. Munk says of William Babbington: "The character of Dr. Babbington was probably as nearly without fault as is consistent with human nature," and we may add to this that he was a great clinician and a man of high scientific attainments. He founded the Geological Society, the Hunterian Society, and helped to found the Royal Medico-Chirurgical Society. If you really wish to hear a fine eulogy—what would each of us give to have the same said of him?—let me read that of Richard Bright on William Babbington—

"He had such a sweet simplicity of character and so profound humility, that while thousands sought his aid as a pearl of inestimable price, he seemed unconscious of his own pre-eminence. He had such benevolence of heart as few have witnessed, an instinctive dread of inflicting pain and delight in doing good. He had so trained his mind to kindness, that a quick answer or an ill-tempered word was never heard to escape his lips. Sorrow always found sympathy in his heart, his hand was ever open to relieve, and the register of heaven alone contains his daily acts of professional charity. In him was to be found an excellent example of that wholesome and yet comparatively rare combination of knowledge which unites our professional pursuits with the study of the natural sciences, which connects the physician with the philosopher; and thus he found time to gain a well-merited reputation not only as a chemist, but mineralogist and geologist, at a time when these were in their infancy. Such were a few of the characteristics of this truly great man, this almost perfect physician, who was an honour to our College, an ornament to our profession. No man ever passed more hours in the conscientious discharge of duty; no man by his personal exertion ever did more good. The comeliness of virtue will always be felt and acknowledged by all whose estimation is worth the good man's desire. With regard to our departed friend this has proved the case, for no man was ever more extensively beloved, no man's example has had more weight, to no one are we more indebted for supporting and exciting amongst us a high tone of moral feeling. Such is the man whom the good delight to praise, such the physician whom we deplore, and as long as the record of our profession shall exist, so long will his name be passed down as a bright glory on its pages."

William Babbington belonged to that rare and happy group of men who, however their attainments may have contributed to their fame, remembrance of them goes down to posterity because of the intense affection of their contemporaries for them. Such a man, you remember, was that poor consumptive clergyman, John Sterling, so beloved by all his friends, that biographies of him were written by two of them, and one of these, Carlyle's, will remain for ever high up among the great biographies of all time.

John Haighton began life as an anatomist, became a distinguished physiologist, and practised as an obstetric physician, which office we find him holding at Guy's. He was a man of very great ability, for in addition to his medical attainments he was a distinguished mathematician.

James Curry was a learned physician at Guy's, who gave to a disordered liver the credit of most ills, hence he prescribed calomel for almost all his patients. The students said he always peppered with calomel the sandwiches that he had for lunch. He was irascible. The minutes of the Physical Society show that on one occasion he took offence and resigned

his presidency of it, and that he persisted in refusing to reconsider his resignation.

The Physical Society during its existence held between two and three thousand meetings, therefore I cannot refer to them in any detail. Perhaps the most famous was that held in 1802, at which Jenner gave an account of the discovery of vaccination. I transcribe the following from Baron's Life of Jenner, 1827, p.538:—

"But the proceedings of this kind which were calculated to convey to the heart and mind of Jenner, at this time, the greatest satisfaction, were those of the Physical Society of London (this, of course, is incorrect; it should be the Physical Society of Guy's Hospital) which holds its meetings at Guy's Hospital, Southwark. At one of these meetings, unusually full, a memoir on the subject of vaccine inoculation underwent long, serious and simple discussion. Dr. Jenner himself attended on four successive nights, having received an express invitation and request from the Society for that purpose.

"On entering the theatre he was constantly received with universal and rapturous applause, and as no discussion was ever of greater importance or of deeper interest, none probably ever attracted in a higher degree the attention of professional and scientific men. At the conclusion of this animated debate, the Society expressed to Dr. Jenner their deep sense of the value of his discovery, 'their opinion of its efficacy and their profound veneration for its author.' After professing their conviction of the prophylactic powers of vaccination, and that it is quite free from any such effects as that of 'calling forth those latent seeds of disease which occasionally arise after small-pox, even under the best management,' the Society thus expresses the sentiments of its members—'We feel the warmest sensations of gratitude and respect for the liberal manner in which the author has communicated his discovery, uninfluenced by any motive of self-consideration; and we contemplate the discovery itself as a memorable epoch in the annals of medicine. The Society presumes to hope that the author of this happy discovery will meet with that reward from his grateful country which he justly deserves for having thus rendered himself the benefactor of mankind.' A new order of merit was instituted on this occasion, the members of which are called Honorary Associates. This distinction is to be conferred solely on the authors of some remarkable discovery in medicine. The President, after an eloquent oration, presented to Dr. Jenner the subjoined Diploma."

John Birch, a surgeon to St. Thomas's, wrote a pamphlet against vaccination, and a quotation from it shows the great interest the subject aroused. He says "The anniversary of Mr. Guy's Hospital was held in 1802, where I expected to meet the Professors, the medical gentlemen and the students on the same terms as usual. What was my surprise, then, to find that the sole business of the meeting was to begin a canvass for names to a Petition to Parliament in support of Dr. Jenner's Bill. I refused to sign it. My surprise was increased after dinner to find that toasts, songs, and compliments from one professor to another in honour of vaccination were the order of the day."

The Bill referred to was one promoted to give a gratuity to Jenner. The Government proposed £10,000; an amendment was moved that it should be £20,000; but the Government carried the lesser sum by a small majority.

But the length of the debate on Jenner's paper was exceeded in 1793, when a friend of Cline, the surgeon, read a paper entitled "An Essay towards a definition of Animal Vitality." The debate on this subject lasted for six successive evenings. In 1797 a debate on "Fermentation" lasted four evenings.

You will often find John Hunter's ligature of the femoral artery for poplitcal aneurysm mentioned in medical literature. As recently as this October (B.M.J., 7, Oct. 18th, 1919) Professor Keith alludes to it. He says "Hunter's ligature of the femoral artery for popliteal aneurysm was but a minor issue of a great discovery, namely, that Nature has provided every part of a living body with a mechanism which secures a sustenance when the main blood channel has been blocked. . . . So far as our knowledge of its exact nature is concerned, it stands to-day just where Hunter left it." This operation of Hunter's was described by him before the Guy's Physical Society. In 1812 the great Bright read a paper on blood letting. No account that I can find exists of this paper. It would be of

immense interest if we could know his views on the subject, for it was only 18 years later that Marshall Hill published one of the classics of Medicine, "Researches principally relative to the Morbid or Curative Effects of Loss of Blood," a book which may be said to be the starting point of our knowledge of the harm of indiscriminate venesection.

(To be continued.)

Leaves from a Medical Note Book

(1914—1918).

VIII. Some Cases of Severe Gastro-enteritis (?) due to Gaertner's Bacillus.

DURING the summers of 1916, 1917, and 1918, there came under the notice of the writer six cases of acute gastro-enteritis, all very gravely ill, and presenting symptoms suggesting cholera. One case ended fatally.

In every instance the history was short—twelve hours or less — and the predominant symptoms had been vomiting, purging, abdominal pain, and muscular cramps, especially affecting the gastro-cnemii. In no case was there any clear evidence which incriminated any particular food; with the exception of two men, who had had some sardines, all had been on the usual rations, and all had been previously fit. On two occasions (accounting for four out of the six cases), two cases came in together, and the first two cases seen belonged to the same unit. There was thus a presumption of some common source of infection.

On examination the men were found to be collapsed, cold, pale, and sweating, and either pulseless or nearly so. All showed slight cyanosis of lips and ears, a pinched appearance of the facies, and eyes sunken in their sockets. The dejecta were greyish-white and watery, conforming well with the description of "rice-water stools." The mental state was dull and confused, but restlessness associated with sighing respirations were noted in the most severe cases.

The treatment adopted was as follows: The men were put to bed and warmth was applied either by means of blankets and hot bottles or with a hot-air bath. Ol. Ric. 1 oz. was given with a little brandy by the mouth, and followed in two or three cases by morphia gr. $\frac{1}{4}$ hypodermically. Boiled water ad lib. and sod. bicarb. alone were given by the mouth. In three or four cases one pint of hypertonic saline was given intravenously; this produced a temporary improvement in the pulse, except in the fatal case, but was twice observed to be followed by a severe rigor, a phenomenon which the same solution did not induce in wounded men. Within twenty-four hours the diarrhœa, sickness, and all grave symptoms had disappeared, except in the fatal case, and in one other which was seen at a main-dressing station and evacuated, but concerning whom no further information could be obtained.

The fatal case showed congestion of the mucosa throughout the small intestine with extensive greyish superficial sloughs, but no localised ulceration.

Bacteriological investigations of the stools in life were negative, but a swab from the intestine of the fatal case gave a growth of an organism resembling Gaertner's bacillus in its agglutinative reactions. No organism suggesting the vibrio of cholera was found.

(To be continued).

Guy's Hospital Physiological Society.

A MEETING of the above Society was held on November 21st. Dr. Laidlaw very kindly took the chair.

Mr. Spurrell read a paper on "The Physiological Aspects of Glycosuria." Alimentary glycosuria could be produced by oral feeding or subcutaneous injection of glucose, but it was practically impossible to induce such a condition in a normal animal on excessive carbohydrate diet, as the liver could deal with sugar at a greater rate than the alimentary canal could produce it. Certain forms of malnutrition as evidenced in tramps and starving animals reduced sugar-tolerance, and alimentary glycosuria resulted on an ordinary carbohydrate diet.

Rapidly fatal glycosuria was produced experimentally by extirpation of the pancreas—glycogen and protein were both broken down to form glucose, but the evidence was against the conversion of fat into sugar in diabetes. This excess of sugar in blood and urine might be due to impaired powers of oxidation in the tissues or to increased hepatic activity. The "Polyglandular Doctrine" of Vienna favoured the latter view, and brought evidence to show that a state of balance existed between the pancreas and

parathyroids on the one hand and the thyroid and suprarenals on the other—the removal of the pancreas upset this balance and left the suprarenal element predominant. Allen in his experiments on "border-line" dogs had disproved this theory, showing that the effects of these gland groups acted on the central nervous system. He advocated the theory of a pancreatic amboceptor which linked on to the glucose molecule, forming a substance easily oxidisable by the tissues, this amboceptor being an internal secretion of the islets of Langerhans. Deficiency of islet tissue meant deficiency of amboceptor, and so of combustible material.

Asphyxia might produce glycosuria as a result of the increased acidity of the blood, which would favour diastatic activity, and in the same way adrenaline, by raising the blood pressure, might produce asphyxial conditions in the liver, and so the increased acidity would lead to increased glycogenolysis.

The kidney in its capacity as filter would affect the sugar concentration in the urine if its permeability were altered as in the case of diuretics, renal poisons or infection. Phloridzin produced a form of renal glycosuria which must be attributed to a specific secretory action of the kidney tissues.

The action of the central nervous system in producing glycosuria was an example of Nature's methods of mobilization in the face of danger. *Men in positions of constant strain such as sea-captains or engine-drivers were prone to diabetes.* Students before examinations showed signs of glycosuria. Cold and stimulation of different nerves such as the cardiac depressor or sciatic produced glycosuria as a reflex probably along the splanchnic nerves to the suprarenals.

Allen's experiments on diabetes led him to believe that it was impossible to convert a non-diabetic into a diabetic simply by heavy carbohydrate diet. Some nervous or circulatory upset was necessary, and he found in most cases the nervous upset was accompanied by changes in the islets of Langerhans. This led him to the following conclusion as typical of the sequence of events in diabetic mellitus —Nervous upset, impaired functions of islet tissue, deficiency of pancreatic amboceptor, increased hepatic activity and tissue breakdown, hyperglycæmia, glycosuria.

The meeting was then thrown open to discussion. The case of phloridzin glycosuria was raised, and increased kidney permeability was suggested as the cause. Dr. Laidlaw explained that the phloridzin acted as a catalyst breaking down into phoretin and glucose on one side of the tissue, then passing to the other and picking out glucose from the blood and reforming phloridzin.

The case of English residents in Bengal who as a class are very prone to diabetes was brought forward. Large carbohydrate diet, little exercise, and continual brain-work were the outstanding features of the case. Dr. Pembrey claimed this as evidence of the beneficial effect of muscular exercise in diabetes, though other members claimed it as evidence of the effect of continual nervous strain.

Dr. Laidlaw said evidence of change in the islet tissue of diabetics was very scanty. The amboceptor theory, though very convenient, was not supported by any direct evidence, and it was exceedingly doubtful whether diabetic tissues were deficient in oxidative power. No experiments in connection with diabetes had been satisfactory or conclusive.

Dr. Pembrey considered that the only explanation of the low respiratory quotient in diabetics was that fat was converted into sugar, and the further evidence of the respiratory exchange of hibernating animals rather confirmed it. The constant "dextrose-nitrogen excreted" ratio was evidence against this conversion.

The meeting closed with a vote of thanks to Mr. Spurrell for his paper, and to Dr. Laidlaw for his valuable assistance from the chair.

Guy's Hospital Dental Society.

A MEETING of the above Society was held on Thursday, October 16th, 1919, in the College Smoking Room at 8 p.m. Mr. F. Bocquet Bull presided. The minutes of the last meeting were read and confirmed.

A proposal which had been brought before the Committee for consideration was presented to the meeting, and it was decided to hold a dance early in the new year. The price of tickets was fixed, and the further arrangements left in the hands of the Committee.

The President announced the conditions under which the Dental Society prizes would be awarded. There are annual prizes of £5 and £1 awarded to students for the best paper and the best casual communication respectively.

After a brief inaugural speech by the President, Mr. A. R. Cox read a paper on "A Specimen of Early American Dental Art." Through the kindness of Mr. Fenton, a member of the Anthropological Society, who has recently relinquished an official position in Guatemala, the lecturer was abundantly provided with specimens of the skulls, images and instruments belonging to the people of whom he was speaking. Many of these specimens presented great interest, especially the peculiar skulls with their broad, flattened occipital bones,

Mr. Cox dealt exhaustively with the known history of this pre-Aztec civilisation, gave a short account of their worship, customs and craft, and then exhibited a specimen of inlay work, which had been discovered among the cremated remains found in a grave probably 500 years old. From their images, the sudden collapse of the race, the typical mutilation of their teeth, and from the popular mythology of the time, the lecturer deduced a theory that their worship was given to the Sun-God, whose visible form was shown as a typical congenital syphilitic. He explained the common mutilation of teeth by filing and the insertion of pyrites fillings into sound teeth in the light of this theory.

As a specimen of dental art, executed with crude tools, the inlay was a remarkable example not of conservative but decorative dentistry, which had survived five centuries.

A short discussion followed, to which a number of members contributed. Mr. Fenton, in a brief speech, heartily congratulated the lecturer. The meeting then terminated.

The next meeting of the Society will be held on Thursday, November 27th, when Mr. Lauer will read a paper on "Dental Surgeons and Dental Surgeries." On December 18th Mr. W. A. Easton will read a paper on "Radiography in Dentistry."

Members are requested to collect and present casual communications of interest to the meetings of the Society.

The Dental Dance will be held on Friday, January 9th, at the Hyde Park Hotel.

Change of Address.

M. B. M. Tweed, 92, Hobson Street, Wellington, New Zealand.

S. Woolf, 29, Orchard Street, Portman Square, W.1., and London Jewish Hospital, Stepney Green, E.1.

Captain O. St. L. Campion, R.A.M.C., c/o R.A.M.C. Headquarters, Black Sea Army, Constantinople.

F. L. King, L.D.S., Arran, Blake Hall Road, Wanstead, E.11.

Lieut. C. G. Coombs, R.A.M.C., Military Hospital, Spilne Island, Queenstown, Co. Cork.

Major G. F. Thomson, M.B., I.M.S., c/o Messrs. Grindlay, Groom & Co., Parliament Street, S.W.

R. Curle, Old Studley, Bournemouth.

R. Quesada, from 69, Connaught Street, Hyde Park, to San José, Costa Rica.

G. T. Willan, 3, Goschen Road, Carlisle.

Two Cases of Retroperitoneal Hæmorrhage.

Mary A., æt. 30, was admitted 5th October, 1919, under Sir Alfred Fripp for abdominal pain, vomiting and constipation. Patient was married and had had four children, all of whom are well. Her mother and father both died from pulmonary tuberculosis, and also her brother. She herself had suffered from anæmia, and had had one eye removed for some tubercular trouble. She had signs of phthisis at her left apex.

History of Present Disease.—Patient's last baby was born nine months ago. The day before birth patient slipped and fell heavily on the pavement, but felt no ill effects after it. Six months ago patient had dragging pains in her right loin, and then she noticed a swelling there which moved as she turned on to her side and then on to her back. She paid no attention to the swelling, and carried on with her work. Her appetite was good and her bowels were regular. On the 4th October (the day before admission) she suddenly had a violent attack of pain in her right hypochondrium, and she vomited a greenish coloured fluid. The pain and vomiting persisted the whole night. She had been constipated the last four days.

On Admission, at 2 p.m., 5th October, 1919. Pulse 98, temperature 99·2°, respiration 24. Patient looked ill, and was covered with a cold sweat, and her tongue was furred. She complained of great pain in her right side, and that she felt as if she wanted to vomit but could not do so. The pain travelled round into her loin, and into her back on the right side. On examination she had phthisis at her left apex. Abdominally, her abdominal wall moved well on respiration, but she was rigid and tender over a small area in her right hypochondrium. A vague swelling could be felt bimanually in the right hypochondrium, and there was tenderness and swelling in the right loin. Her urine was normal, and rectal and vaginal examination revealed nothing. A turpentine enema was given, but was returned.

After being in bed for a couple of hours she felt easier, but at 7 p.m. the pain returned worse than before. She was now definitely tender and rigid over her right rectus, and there was a vague suspicion of a palpable tumour in the right hypochondrium. It could not be traced upwards or downwards. She was not tender under her right costal margin or for an area about 1½ inches below it. Her pulse and temperature, however, had both come down, so she was given hypodermic injection of morphine, gr. 1/6. By 10 p.m. she was much easier, and she had a fair night's rest.

At 10 a.m. on the 6th October, 1919 (the day after admission) she began to vomit a large quantity of greenish coloured fluid. On abdominal examination she was very rigid and tender in her right hypochondrium, with some swelling of her right loin. The previously small tender area had now increased in size, having extended as far laterally as her left rectus muscle, and downwards into her right iliac fossa.

By 12 mid-day she had vomited four times, and she was now beginning to be distended, and there was now to be seen visible peristalsis on the left side of the abdomen above the level of the umbilicus.

Mr. Turner saw patient at 1.30 p.m., and advised laparotomy. The diagnosis was held over, but an acute cholecystitis was suggested or an appendicular abscess, but the difficulty in these was how to explain the visible peristalsis.

Patient was operated on, and the abdominal wall opened by a right paramedian incision. On opening the peritoneal cavity distended transverse colon forced its way out. On examination of the abdominal contents the whole large gut was distended, but the small intestine was not, nor was there any cause of obstruction found. The kidneys, gall bladder, stomach, pancreas, appendix and pelvic organs were normal. There was, however, found a large retro-peritoneal recent hæmatoma. The maximum amount of clot was behind the hepatic flexure of the colon and the clot extended downwards as far as the mesentery of the appendix and to the mid-line as far as the aorta. There was no obvious cause for the hæmatoma. There was no free blood in the peritoneal cavity. The intestines were returned, and the abdominal cavity sewn up.

Great difficulty after the operation was experienced in getting patient's bowels to act, in spite of frequent doses of ol. ricini, calomel and other purges. She also had frequent enemas. After they had once begun to act well no difficulty was experienced.

She did very well after the operation, and at a later date she was x-rayed, but no evidence of either thoracic or abdominal aortic aneurysm was detected. She was discharged on October 31st, 1919, feeling much better and looking very well.

Charlotte B., aged 44 years, was admitted January 15th, 1903, under Dr. Hale White (Med. Reps., 1903, Hale White, No. 35) for pain in the back, right side and right iliac region. Patient had been married for 20 years to a tuberculous husband, and had had seven children, all of whom had died young, the cause of death in six being chest trouble, and in the remaining one diphtheria.

Previous Illnesses.—Two years before admission patient had an attack of severe pain in the sacral region, extending to the right side. This passed off in a few days, but since then she has had numerous similar attacks at intervals varying from a week to two months. In November, 1902, patient "brought up' blood clots and fainted, but felt better afterwards.

Present Illness.—On January 10th patient had an attack of pain in her right side of such severity that she had to take to her bed. The pain subsequently extended to the sacrum and right "inguinal"* region. Since the onset of the pain there had been absolute constipation, neither flatus or fæces being passed. Her bowels had always acted regularly until the first attack of pain, but these attacks were always associated with constipation. There had been one attack of vomiting a day or two before she was admitted.

Condition on Admission.—Patient was thin and cachectic. The abdomen was thin-walled and distended. "Surface was irregular owing to protrusions of numerous coils of distended intestine. The abdomen moves well on respiration. Peculiar irregular twitchings of the right rectus and external oblique muscles were noticed."† On palpation the right "inguinal" region was very tender, and there was a marked increased resistance of the muscles on the right side of the abdomen. Occasionally it appeared possible to feel a firm mass in the right "inguinal" region, but a minute or two later this would be impalpable. The abdomen was tympanitic on percussion. Patient also complained of a gnawing pain in the back, which was increased by movement.

Various enemas and ol. ric. were given without any result. Dr. Bryant and Mr. Dunn saw patient, and concluded that the diagnosis rested between appendicitis, chronic intussusception, and malignant disease of the cæcum and ascending colon. As the general condition was good it was decided that there should be a further period of observation before operation. For two days the condition remained unchanged in spite of further enemas and purgatives.

Operation.—(Mr. Dunn) on January 18th. The abdomen was opened by an incision 4 inches long in the right semilunar line. The whole of the intestine, both large and small, was examined, but no obstruction was found. There were numerous scybala in the colon. It was noticed that the lymphatics of the omentum were very distended with chyle.

On the day following small doses of calomel were given hourly and followed by an enema, with the result that the bowels acted several times and the patient was better.

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*This is the word used in the report. From the context it is evident that the iliac or hypochondriac regions are meant.

†Undoubtedly visible peristalsis was present and is described in these words in the report. The presence of visible peristalsis was noted by the Registrar.

This improvement was maintained for several days, but on January 23rd in the evening the patient suddenly collapsed, and, in spite of restoratives, died early in the morning of the 24th. At the post-mortem examination a ruptured abdominal aortic aneurysm was found. The sac, which was as large as an orange, was situated immediately below the diaphragm. The aneurysm had ruptured at its lower right hand corner, the aperture being the size of a florin. There was extensive erosion of the last dorsal and the first two lumbar vertebræ. There was a very large amount of retroperitoneal hæmorrhage, blood being extravasated beneath the peritoneum over the whole of the right side and down into the right side of the pelvis.

The resemblance of the two cases above to one another it must be admitted is unique, both as regards history, symptoms, signs, and what was found at operation.

I am indebted to Sir Alfred Fripp for permission to publish the case, and to Mr. Turner, who so kindly supplied me with the notes of the second case.

T.G.D.B.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—There are in the current issue of the GAZETTE two contributions dealing with the subject of Medical Research. One from my old friend and pupil, Dr. Cleveland, deploring the possibility of Clinical Ward in the future becoming a Research Ward, and the other, by Mehta, warning ordinary mortals against wasting their time on Research, which, he holds, can only with safety be left to the experts. The views with regard to Research, which are indicated by the fears and warnings expressed or implied in these contributions, are widely held, and are, I believe, very detrimental to the progress of medicine and indeed of all knowledge. The idea that research is a special function only to be acquired by a few brilliant persons, and these only by a special training, is, I believe, as erroneous as that such training and the exercise of such function is detrimental to the practical man. Research is the seeking for knowledge. We are all researchers when we are young. We then observe every strange thing, and we want to know why it is and what it does. This priceless curiosity is gradually lessened by ignorant nurses and fathers, and is later on almost completely destroyed by our schoolmasters. If there should be any of it left in us when we enter a medical school, this little is finally eradicated by preparation for external examinations in anatomy and physiology; and the only point on which the majority of us desire enlightenment by the time we get into the wards is the nature of the questions likely to be asked by the examiners at the finals.

The progress of human knowledge will advance more rapidly if we recognise that it is only by faulty education that we have lost our power of research, and that by right education we might most of us regain it, than if we regard mankind in general as naturally incompetent in this respect and set out to train a special small group of supermen to do our research work for us. Some confusion seems to have arisen between research which is the observation and record of facts, and the interpretation of the fundamental principles that may be deduced from such facts when observed. History would seem to indicate that the type of mind that is able to grasp new principles and formulate great natural laws is very rare. This power is probably a special inborn gift entirely independent of the mere power of observation, and is as likely to be found in the practical worker as in the highly-trained so-called Researcher. The genius who possesses it is as liable to draw his deduction from another's as from his own observation. But there must be observation.

Properly conducted with adequate resources, staff, and assistance, there is no reason why every step in the investigation and treatment of a patient in a hospital should not constitute a research, viz., a careful observation followed by an accurate record. Every individual employed in the investigation and treatment of the patient from the surgeon to the dresser and even the nurse should, in the process, be trained in research. Every general practitioner educated in such a school should go forth a trained researcher, and the ideal of Sir James Mackenzie with regard to the beginnings of disease might thus be realised. The most enthusiastic supporter of things as they are, if there are such supporters in these days of reconstruction, must admit that even in the best regulated hospitals the work falls far short of the ideal here set out.

If Dr. Cleveland would accept the views here expressed as to the scope and nature of research to which all should strive to attain, I believe he would agree that a clinical ward run on these lines would be even more valuable, both to the patients and the clinicals, than the old clinical to which he and I look back with so much affection.

I understand that it must be nearly three years before the new clinical ward to be built at the top of Hunt's House will be ready for occupation. Is it too much to hope that by that time not only clinical but all the wards of Guy's Hospital will be devoted to Medical Research, collectively by turn-

ing out valuable records which Mehta will be able to pass as being the work neither of "dabblers nor advertisers"?—I am, yours faithfully,

LAURISTON E. SHAW.

Boreham Wood,
Herts.

DEAR SIR,—May I draw your attention to the laxity in returning "P.R.D." cards from the various out-patient departments. In the past month I must have sent between twenty and thirty such cards, and I have only had two returned to me.

It is quite impossible for a dresser to follow each case in which he is interested to the out-patients, and he becomes extremely disheartened if every request for an authoritative diagnosis is met with a blank silence. Surely it is a small thing to ask that the physician or surgeon should briefly write his opinion of the case on the out-patient card and return it. I feel certain that such a practice if scrupulously carried out would greatly enhance the interest in the front surgery, and be of immense practical importance in promoting accurate clinical work.—I am, Sir, yours faithfully,

ALLAN McKENZIE.

Guy's Hospital,
November 11th, 1919.

Appointments.

University.

Sir Cooper Perry, M.A., M.D., F.R.C.P., to be Principal Officer of the University of London.

The following appointments are announced:—

Surgical Assistant to Sir Alfred Fripp: Mr. T. S. Keith, M.B., B.S.

Assistant in the Department for Children in place of Dr. Ryle resigned: Mr. H. C. Rook.

Civil.

F. L. King, L.D.S., to be School Dental Surgeon to Essex County Council.

I. Tewfik, Hon. Anæsthetist, St. Bartholomew's Hospital, Rochester.

Trevor B. Heaton, M.B., B.Ch., Lee's Reader in Anatomy at Oxford.

R.A.M.C.

Temp. Capt. (Act. Major) F. D. Saner to be Act. Lieut.-Col. whilst specially employed.

Temp. Capt. P. D. Scott relinquishes his commission and retains rank of Capt.

R.A.F.

Transferred to unemployed list:—Capts. L. B. Stringer, R. J. Hearn.

Dental Branch:—2nd Lieut. (Act. Capt.) G. W. Allen to be 2nd Lieut. and retains rank of Capt. whilst so employed.

Guy's Hospital War Memorial.

Brought forward	£5038	13	4
Ta'Bois, Fred W.	1	1	0
Sells, R.	2	2	0
French, Herbert*	10	10	0
Hearnden, E. Morgan	2	2	0
Jones, D. R.	2	2	0
Lamb, Charles J.		10	6
Rogerson, Harold	5	5	0
	£5062	5	10

*First instalment.

Guy's Hospital Debating Society.

THE Annual Ladies' Night Debate will be held on Thursday, December 11th, at 7.30 p.m.

Mr. J. H. Burn will propose—"That in the opinion of this House, the progress of mankind is dependent upon unconventionalism."

Mr. G. P. Lindsay will second the Opposition. Now that the numbers of the Hospital are at full strength, it is hoped that Guy's will not allow itself to be outvoted as it was on the last occasion!

Reviews, etc.

Essentials of Chemical Physiology, by W. D. Halliburton, M.D., L.L.D., F.R.S. (Messrs. Longmans, Green & Co., 10th edition, pp. 324, 7s. 6d. net.).

The tenth edition of this text-book still retains those characters which render it at once an excellent practical book for the laboratory and an interesting theoretical manual. The practical experiments at the beginning of each chapter are put out clearly yet concisely, and the text of the chapter contains all that is necessary for the proper understanding of the fundamentals of chemical physiology in all its latest aspects.

Medical Science: Abstracts and Reviews.—Published for the Medical Research Committee by Humphrey Milford. Oxford University Press. (Price 2s. per month).

Those who had the opportunity of reading the Medical Supplements issued during the war by the Medical Research Committee may perhaps be a little disappointed with the first issue of "Medical Science." It may quite well be that the topical interest of abstracts culled from the current literature was greater before the armistice; it may also be that the period now under review has been a comparatively unproductive one, but surely some subject of more outstanding importance might have replaced or preceded the opening article on Spina Bifida.

Since the reviews do not confine themselves strictly to a discussion of the quite recent work, some account of the American investigations on the Pneumococcus, of the researches of Mellanby and others into the Deficiency Diseases, or of the advances in blood-transfusion—all of them studies which have made especial progress within the past eighteen months or two years—might well have found a place.

Setting aside criticism, however, the present issue contains some definitely useful reviews of the recent researches on Infective Diseases, on Cardio-Vascular Disease, and on the Repair of Tissues. The abstracts recount much of the quite recent work of importance in bacteriological and pathological fields, including experiments by Bullock and Cramer "On a new factor in the mechanism of bacterial infection," with the gas-forming anaerobes, Noguchi's description of the Spirochæte of Yellow Fever, and some suggestive observations by Cramer on the functional activity of the suprarenal glands in health and disease.

The letterpress and general production of the journal leave nothing to be desired, and the references are particularly full and clear.

Of such importance is the publication of summaries and reviews of this nature, since it is nowadays so hard to keep abreast with the literature and advances of medicine and her sister sciences, that it is greatly to be hoped that "Medical Science" will come to merit a wide distribution. If it aims at a high standard of utility as well as providing an index of current scientific lore it is likely to do so, and to become a valuable addition to the medical press in this country.

Manual of Diseases of Children. By James Burdet, M.A., M.D., M.R.C.P., Edin. (Messrs. E. & S. Livingstone, pp. 410). Price 8s. 6d. net.

A second edition of this useful little book has appeared. In spite of its size, it is full of information. The first chapter on the examination of sick children shows that the author is a man of remarkably wide experience of children, and also that he has made full use of his experience. This chapter should prove very useful to the young and inexperienced practitioner. There is also much sound common-sense in the author's remarks on breast feeding. Perhaps too much stress is laid on the dietetic treatment of rickets, while summer diarrhœa is dogmatically stated to be "infective." In his section on enuresis, the author, in our opinion, does not lay sufficient stress on the nervousness which forms so large a part of the etiology of that affection, and writes rather much on the somewhat doubtful organic causes. In fact, the nervous child has received but scant consideration in the whole book. There is very little mention of pathology or pathological anatomy, which somewhat mars the value of the book from the student's standpoint. The illustrations are remarkably good, and, on the whole, the book should form a valuable addition to the library of the student and young practitioner of medicine.

Football.

GUY'S v. UNITED SERVICES.

On Saturday, November 8th, The Hospital achieved a great win over the United Services, and almost the whole of the game we were one man short, P. Krige having the bad luck to get his cheek bone very badly hurt. Guy's will miss him for some weeks, it is feared, and all will wish him a speedy recovery. About 15 minutes after play commenced Bekker ran in with a try, which was not improved on. Van Schalkwijk played finely, but Portsmouth were the next scorers, Evan-Thomas, the Portsmouth full back, kicking a fine penalty. Till this period of the game The Services had been without Metherall. Reitz was hauled out to take P. Krige's place, and well he played. One would almost like to see Reitz permanently installed in this position. His pace is good and hands safe, and his knowledge of the game unsurpassed. Guy's have so many good reserve forwards it could quite well be done. Many attempts were made by both sides to score, but Guy's managed to gain a good try by Steyn, in an excellent position for Millett to convert.

After half-time The Services forwards were very prominent, Harrison in particular. Strange to relate, the Services forwards played perpetually to their backs. Had they themselves gone on the score might have been different. All praise should go to our pack, weakened by Reitz's absence, and Watson frequently was out to aid defence. Brilliantly Davies sent Reitz in just about 10 minutes before the close. Millett did not majorise, and at that score the game ended. A word should go to Millett's game. He has played splendidly ever since his re-appearance, but at Portsmouth his game was well-nigh perfect. Guy's, 1 goal, 2 tries (11) to United Services 1 penalty goal (3). Guy's team:—

H. Millett, G. L. Steyn, P. J. Krige, H. Graham Davies, P. Krige, F. Bekker, G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, G. R. Aspinwall, G. Zondagh, E. Neser, L. K. Watson, P. J. Biddle, A. Marais.

GUY'S v. CAMBRIDGE UNIVERSITY.

At last we met with defeat. Cambridge are a good side, but it was hard luck to get beaten by such a margin. Satisfactory in a way not to be beaten by more. All the time it looked as if our record would remain, but it was not to be. Several times a score looked certain, but though all tried the end came with Cambridge 2 goals (one a penalty) and Guy's 1 try.

The early part of the game was rather more in our favour than otherwise. Guy's forwards came along with a burst, but Watson managed to touch down and thus prevent a score. Steyn then got away, and was only brought down very near to the line and lost the ball. Then Cambridge scored: the ball was worked up and a scrum near our line ensued, Young swung out and Wood got behind the posts for Lewis to convert the try. Again Wood looked dangerous, and Frubshaw made a mark in front of goal. Luckily for us Lewis missed goal. At half-time nothing more had been scored.

We tried very hard on the resumption. Watson was kept busy, and several times the Hospital seemed to do everything but score. Steyn was held, and Millett had a shot from a penalty. Conway for Cambridge got away after the re-start. From a scrummage near the corner, after some good play by Davies, Krige got our only try, but Millett could not convert. Before the end Watson, the Cambridge full back, tried to drop a goal, which was almost successful, and in the last few minutes Greenwood, the Cambridge captain, kicked a penalty goal from a long distance out.

Looking at the game from a lapse of a few days, one thinks we should have won. There was just a suspicion of lack of determination on one or two occasions. The line, go for it! should be the motto of our outsides nine times out of ten. Guy's team:—

H. Millett, G. L. Steyn, J. Krige, H. Graham Davies, J. Van Nickert, G. Van Schalkwijk, F. Bekker, W. D. Doherty, F. W. Reitz, A. Marais, G. R. Aspinwall, L. K. Watson, E. Neser, G. Zondagh, B. F. H. Duncan.

GUY'S v. LONDON IRISH.

At Honor Oak Park on Saturday, November 15th, the Hospital, with Doherty, Reitz, both Kriges, Millett, Shellswell, Neser and Steyn away, beat the Irish by the large margin of 6 goals 5 tries to 1 try; 45 points to 3. The visitors were three men short for the first ten minutes. Van Nickert and Bekker had scored tries and Crook converted one of them before the Irish team was at full strength. The Irish forwards now played with plenty of dash, but our defence was good. Davies steadied the line splendidly, and his attack was superb. Shaw was the next to cross the line, quite a good effort. Then Davies, opposite the stand, picked up, and, running splendidly, finished behind the bar. Van Schalkwijk converted. The Irish were now rewarded with a try. Hickey was the scorer. Just after, however, they had the bad luck to lose for the rest of the afternoon Fitzgerald. He got a bad cut on the cheek.

The second half was rather a procession over the line. Watson was the first to gain 3 points, followed by Aspinwall. Our forwards were now right on top. They played with splendid dash. Duncan and Zondagh were always prominent. Both halves were good, and the three-quarters, whose movements were well initialed by Bekker and his partner, had a stream of passes. Shaw played quite well, but he must pass with a swing, not a jerk. Davies, unselfish and most efficient, gave Van Nickert opportunities, and twice he ran in, both times showing real grit. Watson crowned a fine afternoon's work with another try, and Van Schalkwijk summed up the weak defence opposed to him by gaining 3 tries. All three he simply dodged through the opposing sides completely. No one tackled him, so elusive and clever was his side-stepping. Van Schalkwijk has never showed to better advantage, and he deserved the applause he got. Davies converted one try, Van Schalkwijk three. Mackenzie had no chance to show what he could do. The visitors' backs were frequently cleared before the passing reached him. Only two tries came from the outsides, and both by Nickert. This proves early penetration of the defence, and the fact that outflanking was unnecessary. Guy's team:—

W. Olivier, M. Mackenzie, T. A. Shaw, H. G. Davies, J. Van Nickert, F. Bekker, G. Van Schalkwijk, A. Marais, L. K. Watson, G. R. Aspinwall, F. W. Crook, G. Zondagh, B. F. H. Duncan, F. J. Biddle, B. L. Lauer.

Hockey.

A meeting of the Hockey Club was held on October 27th.

In the unavoidable absence of Mr. Steward, Mr. Bromley took the chair.

Addressing the meeting, Mr. Bromley mentioned that this was the first meeting since October, 1913. He drew attention to the fact that the Hockey Club were without a ground, and urged that a strenuous effort should be made to obtain one, a permanent one if possible.

The accounts were then read by the Acting Secretary. There was a balance of £6 9s. 11d. from the season 1913-14. The only expenses incurred since then was £15 for the rent of a ground at Surbiton for the season 1914-15.

The election of officers then took place. Mr. Steward as President and Mr. Ormond and Mr. Fagge as Vice-Presidents were unanimously re-elected.

It was proposed and seconded and carried nem. con. that Mr. Hughes, a former member of the Hockey Club, should be asked to become Vice-President.

The following were then elected for the present season:—Captain, Mr. G. L. Cutts; vice-captain, Mr. H. C. M. Coxon; joint secretaries and treasurers, Mr. B. M. Tonkin and Mr. H. A. H. Harris; committee, Messrs. O. G. Morgan, C. R. Cade, D. C. Eglington, J. E. Duckworth, and W. F. Payne.

The following statement was then made by the Acting Secretary.

Owing to the Hockey Club having no ground, it was not possible to arrange any home fixtures, but seventeen games had been fixed up, the first of which would be a friendly with St. Bart.'s on November 15th.

There were between 30 and 40 men who had placed their names down to play, and every effort would be made to run a second team.

On Friday, October 24th, a meeting of the United Hospitals Hockey Club was held at Middlesex Hospital, and it was decided to re-start the Hockey Tournament and also the United Hospital Hockey Eleven.

Two practice games would be held, probably at Richmond Athletic Ground.

A vote of thanks was then passed for the Acting Secretary, Mr. C. Vincent-Brown, for having undertaken the duties of Secretary and calling the meeting.

The meeting closed with a hearty vote of thanks to Mr. Bromley for taking the chair.

St. Bartholomew's Hospital Medical School.

REGULATIONS CONCERNING THE ROSE RESEARCH FELLOWSHIP.

1. Annual value, £600 (exclusive of laboratory expenses).

2. The Fellowship shall be awarded by a Board of Electors appointed by the School Committee of St. Bartholomew's Hospital.

3. The conditions of election and of tenure of the Fellowship shall be as follows:—

(a) Candidates shall possess a registered British qualification to practise Medicine and Surgery.

(b) The Fellowship shall be tenable for one year, and the holder shall be eligible for re-election annually.

(c) The Fellow shall conduct research on the "Pathology and Treatment of Lymphadenoma," and must devote the whole of his time to that work.

(d) The research shall be conducted at St. Bartholomew's Hospital, but the Electors shall have power from time to time to permit any part of the research to be carried on elsewhere than at St. Bartholomew's.

(e) The emoluments of the Fellowship shall be paid to the Fellow quarterly, the first payment to be made at the expiration of three calendar months from the commencement of the Fellow's year of office.

(f) The holder of the Fellowship shall send to the Dean of the Medical School of St. Bartholomew's a full report of the work and results one month before the expiration of the year of office, and the report must be considered by the Electors in deciding the question of re-election.

(g) In making any election or re-election the Electors may at their discretion invite expert opinion on the Candidate's application or on the Fellow's report of his research.

(h) The results of the research shall be published in such manner and place as shall be arranged between the Electors and the Fellow.

4. Candidates in their application shall give particulars of age, degrees, course of education, appointments they may have held and research work they may have done, and shall indicate generally the lines on which they propose to conduct the Research of Lymphadenoma.

5. Candidates shall submit not more than three testimonials, and give the names of three referees who have personal knowledge of their work.

Papers by Guy's Men.

E. G. Slesinger, F.R.C.S., M.B., B.S., Osteitis fibrosa, *Lancet*, November 15, 1919.

Gerald Sichel, F.R.C.S., The Services, B.M.J., November 23, 1919.

Pass List.

University of Oxford.

At a congregation on October 30th the Degree of Doctor of Medicine was conferred on—

C. P. Symonds.

University of London.

THIRD M.B. B.S. EXAMINATION FOR MEDICAL DEGREES, October, 1919.

Honours.

*Jack Joffe, B.Sc.

*Distinguished in Pathology and Surgery.

Pass.

Rolf Creasy. E. D. Scott.
St. G. B. D. Gray. H. W. Southgate, B.Sc.

Group I.

G. O. Hume.

Group II.

E. C. Hinde. G. E. Kidman.
W. J. T. Wallis.

Royal College of Surgeons.

L.D.S. FINAL EXAMINATION, October, 1919.

* R. D. Amm.	J. Lauer.
* C. G. Atkinson.	P. J. Morrison.
F. Brazilier.	F. J. Ordish.
* F. J. Myers.	H. P. Parker.
H. A. Spouse.	W. D. Penfold.
C. C. de A. Birch.	H. M. Smith.
J. Bitar.	H. M. Worth.
E. G. Browne.	E. C. Nicholls.
B. P. Cousins.	T. A. M. Wilson.
L. R. J. Hallett.	L. G. Whelpton.
J. J. L. Hollington.	

*Part I only.

Births.

GIE.—On October 30th at de la Haye, Cape Town, to the wife of Johann Conraad Gie, M.B.London (née Ethel St. Clair Foxon) a son (John George).

FAWCUS.—On October 30th at Chard, Somerset, to Dr. and Mrs. R. A. Fawcus, a son.

JONES.—On November 15th at 77, High Street, Whitworth Park, Manchester, to the wife of J. Arnold Jones, F.R.C.S.Ed., O.B.E. (née Jessie Foxon) a daughter.

MUTCH.—On November 23rd at 16, Harcourt House, Cavendish Square, W., to Eileen Arbuthnot, wife of Dr. N. Mutch, a son.

Marriage.

On November 11th, at St. Peter's Church, South Kensington, by the Rev. Canon C. S. Woodward, Major Graham Yalden Thomson, M.B., I.M.S., to Clare Corol, daughter of Mrs. Mullard, of Llandudno, Wales.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

ONCE again the Residents and Students of this Hospital are being stopped in Maze Pond and St. Thomas's Street by the incessant and somewhat pathetic cry, "Please put our names down for the Christmas Tree!" It is clear, from the frequency of the request, how much the Borough children appreciate the efforts of the Out-Patient and Surgery Staff; how much they treasure that fleeting glimpse of the Christmas of which we, born in happier surroundings, cherish such tender memories; and how keen must be the disappointment of those who apply too late. Those of us who have been on the District can imagine the dismal and joyless Christmas day which dawns for the Borough child, to whom Father Christmas and Yuletide cheer are only another fairy tale which never comes true.

It is not our custom to use these columns as a medium for "begging." And yet on this occasion we feel fully justified in appealing to the generosity of Guy's men for their support for this year's Out-Patient Tea. During the war this annual treat was carried on with great success, in spite of all the attendant difficulties of the time. Last year, although actual fighting had ceased, there was neither time nor money to prepare a real peace-time Christmas treat, although the Tea was a great success even then. But this year, with a record number of men at the Hospital, it is hoped that the children will be given a treat that will far exceed their wildest expectations, that will even out-shine pre-war occasions in magnificence. But at the same time it must be remembered that prices are still extraordinarily high, and that a shilling now will only go as far as sixpence did before the war. So that we ask everyone in the Hospital to help, and to help substantially. Just think what a time the children would have if every one of the six hundred present Guy's men were to give five shillings!

Moreover, we do not only appeal to men up here now, but also to old Guy's men who still read this paper. When you are buying your expensive presents for your own children, when you are sitting in comfort by your Christmas fire, think for one moment what Christmas in Snowsfields or Crosby Row must be like, and spare a little out of your plenty for the Landon Tea Fund.

ONE of the most persistent causes of complaint from the Surgery is the long delay that frequently occurs before the Take-in House

Officer comes to a patient whom the O.P.O. considers he ought to see; all manner of devices have been tried to overcome this difficulty, with but indifferent success. Recently, however, a suggestion has been made from an authoritative source which seems well worthy of a trial, namely, that a system of muffled bells should be introduced throughout the Hospital. Some such arrangement would be made that one ring meant the H.P. was wanted in the Surgery, two rings the H.S., and so on. If these bells were in every ward, the tedious and often unsuccessful practice of "ringing round" on the telephone would be unnecessary, or the requisite number of rings on the telephone bell would carry its own meaning, and the House Officer on duty could proceed to the Surgery without more ado.

Our heartiest congratulations to Mr. R. C. B. Ledlie, late John Atkinson Exhibitioner of the Worshipful Company of Barbers, on being made an honorary Freeman of the Company.

A contemporary, in a "Students' Number," entreats the freshers of the hospital whose opinions it expresses to remember the motto—"Mens sanum in corpore sano." We think it quite possible that the freshers will remember it even better than the editor!

An interesting article appears in this issue about the findings of all sorts of objects of historical interest in the foundations of old "Clinical." Might we suggest that some of these might go to the decoration of the present Clinical's Room in the Medical block, which, even if thoroughly hygienic, does not err on the side of over-furnishing.

At a recent meeting of the Council, Messrs. Winston and Curry were unanimously elected honorary members of the Clubs' Union. All subscribers will be glad to hear that this tribute has been paid to the long and faithful service that these gentlemen have given the members of the Union.

A meeting of the Pupils' Physical Society will be held in the College Smoking Room at 8 p.m. on Tuesday, December 16th. Dr. Tyson will open a discussion on "The Future of Medicine." Dr. Fawcett has kindly consented to occupy the Chair. It is hoped that all men in the wards wil make an effort to attend. The subject of the discussion is of so vital a nature at the moment, when reconstruction is taking place in all branches of the profession, that it is considered unnecessary to point out the advantages of such a discussion in these pages.

Appointments.

R.N.M.S.

Surg. Lieut. Commanders to be Surgeon Commanders:—G. Nunn, F. G. Goble, P. F. Minett.

Surg. Lieut. G. B. Cockrem to be Surg. Lieut. Commander.

R.A.M.C.

To be Captain:—Capt. C. E. Petley, from T.F.

Capt. (Act. Major) C. de W. Gibb relinquishes acting rank of Major.

Capt. W. G. Mumford relinquishes his commission, and is granted rank of Major.

Capts. F. E. R. Laborda, P. Smith, and P. R. Boswell relinquish their commissions, and retain the rank of Capt.

Honours.

Conferred by the Sultan of Egypt

Order of the Nile, 3rd Class—Lieut.-Col. and Brevet Colonel (temp. Col.) W. Holland Ogilvie, C.M.G., I.M.S.

Change of Name.

I, MORRIS COHEN, hereby give public notice that I have assumed and from henceforth upon all occasions intend to sign and use and to be called and to be known by the name of Maurice Coburn only, in place of my present name of Morris Cohen; further, that such intended change of name is formally declared and evidenced by a Deed Poll under my hand and seal bearing date this Eighth day of December, 1919, and intended forthwith to be enrolled in the Central Office of the Supreme Court of Judicature.

In witness whereof I now sign and subscribe myself by my intended future name.

Dated this Eighth day of December, 1919.

MAURICE COBURN.

Sir William Hale White,

K.B.E., M.D., F.R.C.P.

Assistant Physician for only five years and Physician for twenty-nine! Few men have had such an opportunity for distinguished service to Hospital and School, and no man could have made better use of the opportunity a happy future gave him than Sir William Hale White.

The duties of physician to a great teaching hospital are many. He must direct the treatment of his patients, teach his students to become sound practitioners, attempt to advance the science of medicine by observations made under exceptionally favourable conditions, apply his knowledge not only to the advantage of those within the walls of his hospital, but also to the benefit of patients seen in consultation in the outside world and to the instruction by speech and writing of the whole profession.

In every one of these directions Hale White has succeeded in an eminent degree. Countless patients from the Borough and from all parts of England owe their health and often their lives to his skill as a physician. Few men who have been students at Guy's since 1885 have not benefited by coming under his influence. Throughout his career his bedside teaching has been extremely popular, not only with the type of student whose one object in life is to pass his examinations, but also with those who, whether qualified or not, have wished to learn something from his great store of clinical knowledge.

No living man, with the exception of Sir William Osler, has added contributions to so many branches of medicine. His investigations on gastric hæmorrhage, muco-membranous and ulcerative colitis, on cirrhosis of the liver, perihepatitis and pancreatitis, on pneumonia and empyema, infective endocarditis and pericarditis, on exophthalmic goitre and myxœdema, on Addison's anæmia and Hodgkin's disease, on Thomson's disease and combined sclerosis of the cord, on typhoid fever, obscure pyrexias, and fever in general; all these and many more have helped in the great advance in scientific medicine which has marked the last quarter of a century.

Countless practitioners from every British medical school can testify to the help they have derived from consultation in private with Sir William Hale White. Some new light on the nature of an obscure case, some investigation not yet thought of or not yet satisfactorily carried out, some suggestion as to treatment which may result in the shortening of an illness or the saving of a life, these are what they have been accustomed to expect from him.

A voluminous writer, who never wrote anything unless he had something new and interesting to say, one of the few medical authors whose style is as good as his matter, Hale White's clinical lectures, his more serious contributions to the journals, his book on Common Diseases of the Liver, and his articles for Allbutt's System of Medicine and other large textbooks, have been of the greatest value in keeping the profession alive to recent advances in the theory and practice of medicine.

A clinical lecture on pericarditis heard many years ago still stands out in my memory as the model of what a clinical lecture should be. An address delivered in Manchester and published in one of the weekly journals on suppuration in the neighbourhood of the diaphragm is equally a model address to practitioners. And the introductory remarks and still more the judicial summing up in the long discussion on Intestinal Toxæmia at the Royal Society of Medicine shortly before the war were admirable, and showed a well-balanced and logical judgment which was sadly lacking in many of the contributions—especially the surgical contributions—to the discussion.

I am sorry to admit that I could never read Hale White's "Materia Medica," but I have reason to believe that I am in good company, and that the author would never have re-read it himself had it not been for a stern sense of duty each time his publisher calls for a new edition.

For forty-five years "Haler" has been a familiar figure at Guy's. It is the hope of all of us that for many years we shall still often have the pleasure of welcoming him amidst the surroundings in which he has worked so hard and to such good purpose for a whole generation.

Charity and Luke Concert.

The following have kindly consented to give their services:—Mr. Corelli Windleatt and Orchestra, Miss Iris Hoey and Mr. John Roberts, Miss Gladys Banks, Miss Fay Davis, Mr. Gerald Lawrence, Misses Enid and Vera Beringer, and Miss Helen Mar.

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The Physical Society.

Being the Inaugural Address delivered before the Society, November 6th, 1919, by

SIR WILLIAM HALE-WHITE, K.B.E., M.D.

(*Continued.*)

From the earliest foundations of the Society there have been essays on fixed subjects. Certainly one of these was difficult. Thus in 1776 the subject was "In what points of view should the human body be considered, so as to speak of it intelligently yet consistent only with truth and reality?" But the other two in this year were more practical, namely, "Is nutrition performed by the arteries or the nerves?" and "Whether at once to deal with an artery wounded in a venesection or to wait till an aneurysm forms and then treat that." The first of these we still discuss; the second reminds us of the former frequency of venesection. Thousands of people were bled every spring and fall as a precautionary measure. Occasionally aneurysms or even death from pyæmia resulted. Next year the subjects were "What are the causes of the menstrual flux?" and "Whether sufferers from dropsy should be allowed plenty to drink?" A few years later the subject was "Whence the saccharine matter found in the urine of those who labour under diabetes?" You notice that some of the problems which troubled our ancestors perplex us still, and it is sad to reflect that all the learning and research of a century have not completely solved them. But do not let this make you despair, for in several matters, which were among those then most frequently discussed, we have indeed advanced. Hydrophobia was often brought before the Society. Now in this country it is stamped out among human beings, and even if a man is bitten by a mad dog hydrophobia can be prevented provided that treatment is undertaken at once. I am just old enough to have seen several fatal human cases, some under my own care. Untreated—and it was for all the good results that were obtained untreated, until Pasteur's researches were known—it is almost always fatal; the sufferings are intense, and no form of death is more terrible to witness. Properly applied, muzzling orders eradicate it among dogs, and then there can be no hydrophobia among human beings in this country. It is your duty to tell the public this, and to picture to them, what an awful disease it is. Mr. Long, who first made muzzling compulsory in this country, thereby became a benefactor to mankind; but, as you might expect, all sorts of ignorant people abused him fiercely. As Lord Salisbury said, there were those who would vote for a government that would plunge us into a European war provided that such a government would repeal the muzzling order.

I thought I knew how awful hydrophobia could be, but buried in the minutes of the Physical Society for 1795 is the most terrible thing I have ever come across, worse than any tale by Edgar Allen Poe. A member related that a young man, married a few days before, was during the night seized with a paroxysm of hydrophobia. He tore open the abdomen of his wife with his teeth. Both were found dead; he with the intestines of his dead wife wound round his bloody arms.

Many discussions took place on the treatment of strangulated hernia, then a frequent cause of death, and even when I was a student it was a common cause. Now cases are rarely seen in the post-mortem room. Scurvy also was often discussed, for it was then a terrible scourge; but probably now not a single one of you has ever seen a case. I saw several

when I was at the Dreadnought, but for thirty years the only scurvy I have come across has been the infantile form, and the only use of my knowledge of it has been to assure doctors that patients whom they suspected of having scurvy were suffering from some other disease.

Electricity was discussed then as now. The limits of usefulness in medicine were not easy to draw. We can hardly imagine a debate to-day on either exfoliation or putrid fever, but both were debated about 120 years ago.

It is worth while to observe some of the clinical cases which were related before the Physical Society in these times far ago. One was a case of contraction of the elbow successfully treated by carrying a weight in the hand. This seems rational treatment. A woman who grew hairs from her tongue sounds as though now she would arouse considerable interest among pathologists. Probably you will agree with me that there is an error somewhere in this story. A man as a result of an accident fractured his skull and died. Three days later the man who caused the accident died of grief. On more than one occasion in 1783 it was stated that a poultice made from stale beer grounds was most efficacious, making us wonder whether this was due to the antiseptic properties of the alcohol; and in 1795 we have a hint of the same properties of mercury salts, for Mr. Davie related a curious circumstance. Two subjects were brought into the dissecting room at the same time. On the second day one had become putrid, and was covered with maggots. The other adjacent to it was avoided by flies. This patient had been heavily treated with mercury for syphilis. Was, asks Mr. Davie, this the reason why the flies avoided her body? There are many allusions to vaccination. For example, in 1805 Mr. Charlesworth related that out of 5,000 people he had vaccinated, only six had had smallpox, and all these had the disease very lightly; and in 1782 a case was related in which after inoculation for small-pox had taken, a measles rash had appeared. Inflammation at the site of inoculation thereupon became suppressed, but reappeared when the measles rash disappeared.

Some of us are so proud of the application nowadays of scientific principles to medicine that we are prone to consider that our forefathers were not scientific. There is abundant evidence from the old Physical Society that this is quite erroneous. The debates on vaccination and the ligature of the popliteal artery by Hunter are alone enough to refute it. Many experimental results were placed before the Society. For example, in 1794 Mr. Coleman relates that he has been ligaturing the carotid of an ass in two places, and has observed that the blood between the ligatures was coagulated, and he brings these results forward as he considers they have a bearing on the proper treatment of aneurysms. In 1783 Dr. Hawes got up and told those present that he had heard from a practitioner of the case of a man insensible who had been revived by applications of cold. He was particularly pleased to relate this, for in his lectures he had always advised warmth in these cases. Surely scientific openness of mind and candour could go no further than this, and it will be good for us all if we constantly remember Dr. Hawes.

Some of the cases are amusing. For example, we hear of a gentleman who swallowed two guineas, which were passed per rectum; others indicate that times have changed, for in 1806 Dr. Buxton related the case of a woman who, in a fit of despondency produced by losses in the lottery, took rat poison and died, and in the same year Mr.

Pugh told of a young milkwoman who, in the late violent storm of wind, was thrown across her pail, injured her thigh, and gangrene of the leg followed. The milkwoman with her pails hung from either shoulder has long disappeared from the London streets. In 1809 we notice that the day of meeting of the Society has been altered in order that it should not fall on twelfth night.

On March 6th, 1813, the following excellent resolution was passed:—"Resolved that the dresser for the week should be required to furnish whatever may fall under his observation interesting to the Society." What a good thing it would be if this could be enforced now.

The Physical Society not only kept alive, by its meetings, scientific and clinical interest in medicine and thus made itself famous, but it promoted medical knowledge by providing for its members a large lending library. The importance attached to this is shown by numerous references to the library and the librarian in the minutes. Then as now there existed those most despicable of all human beings, those men who will not return books when they have done with them. On one occasion so much was this resented that the meeting nearly came to blows. It would have served him right if the member who took the books but did not return them had been thrashed. Let us hope he paid his fines.

Once there was nearly a tragedy at the Society, but, as you shall hear, all ended happily.

On May 17th, 1783, a letter from Mr. Morrison was read, saying that he resigned his place in the Society because of the great injustice and contempt with which he had been treated at the last meeting at which he was present. Resolved:—"That it appears to this Society that Mr. Morrison has proved himself highly undeserving of the honour conferred upon him in electing him a member, that his complaint of being treated with injustice is ill-founded, and that ye Members were too lenient in requesting him to continue a member after the disrespect he had shown to the Society two succeeding evenings and further that it is the order of ye Society that he never after appear here even in the character of visitor." Next meeting he came and was observed. It was agreed that no business could be transacted in his presence, and he was informed of the above resolution. Nevertheless, he refused to withdraw, but pulling out a pistol from his pocket threatened the life of anyone who should read the minutes of the previous meeting in which his character was stigmatized. In consequence of this interruption the President adjourned the meeting to Dr. Babbington's parlour. In a short time Mr. Morrison took his departure and the members returned to ye Theatre, and the ordinary business proceeded. At the end of this and after papers had been read it was resolved "That as the Hon. Sec. appeared to be the person against whom Mr. Morrison's threats were chiefly directed, that the Society should support him in ye expense to which he might be put in proceeding according to law against Mr. Morrison," and a committee was appointed to support him.

Next meeting the Committee reported Mr. Morrison had signed in the presence of Justice Levy a letter in which he acknowledged the impropriety of his conduct and that he would never attempt anything like it again. Whereupon the Society resolved that it be entered on the minutes

"That it is ye opinion of this Society that Mr. Morrison has done everything that could be expected of him as a gentleman, and that ye

Society therefore admit his letter as sufficient apology."

The Physical Society of Guy's Hospital had become so celebrated and had demonstrated so completely the great advantages to be derived from meetings and discussions that in 1830 the then students of Guy's Hospital founded the Pupils' Physical Society, which is the Society I am now addressing. It has existed, therefore, 89 years, and has, we all trust, still a long life before it. The minute books of some of its earlier years still exist carefully kept with the most beautiful handwriting. The rules were simple. Only students of Guy's Hospital could be members, the staff could be honorary members, the subjects of discussion must be strictly medical or surgical, the fee of membership to be 2s. 6d., and the time of meeting 8 to 9.30 alternate Saturday evenings. Among the first members and honorary members were Curry, Hilton, Bransby Cooper, Hughes, Key, Stocker, John Morgan, Astley Cooper, Monson Hills, Hodgkin, Bell (the dentist), Addison, Babbington and Rees. Probably never did a Society begin with such a distinguished membership. Well might Dr. James Blundell on November 20th, 1830, write thus in thanking for having been made an honorary member :—

"I feel a confident expectation that many who are now enrolled among its members will, by their future fame and fortune, in turn reflect upon the Society with increased lustre, the reputation which they may derive from it.

"I have the honour to remain,

"Dear Sir, with consideration,

"Your obedient servant,

James Blundell.

Mr. Cock, familiarly known as Teddy Cock, was the first President of the Pupils' Physical Society. He was Consulting Surgeon when I entered, and many times have I seen him in the theatre at Guy's watching the younger men operate. He and Sir Samuel Wilks have been the most beloved Guy's men since I have known Guy's. I remember after one of my first biennial dinners Teddy Cock offered me a seat in his four-wheeled cab. There was a crowd of old Guy's men around the cab all wanting to shake hands with and say good-night to dear old Teddy Cock and to express their jealousy of my being asked to share a cab with their hero.

With the exception of the suspension during the great war meetings have taken place regularly every winter session since 1830: cases have been shown, papers have been read, discussions have been held, and essays have been written. In the early days we find, just as in the early days of the parent society, the proper treatment of strangulated hernia was frequently discussed; tobacco enemata was thought to be useful, but the mortality, with or without operation, was very high. The subject of erysipelas, the disease so dreaded by surgeons and obstetricians before the introduction of antiseptics, was frequently before the Society; on one occasion four successive meetings were devoted to it. In 1840 Gull became a member, and read a paper on Diseases of Pregnancy especially Mania, but it is clear that most of his cases were examples of low-muttering delirium accompanying the awful puerperal septicæmia so frequently following confinement. In 1838 there was a discussion on valvular disease of the heart and the murmurs associated with it. At the 87th meeting, held in 1837, a vote of thanks was passed to the Clinical Report Society, which was an association of students anxious solely for their own good to make proper reports of the cases in the hospital. This Society naturally ceased to exist when ward clerks were appointed whose duty it was to

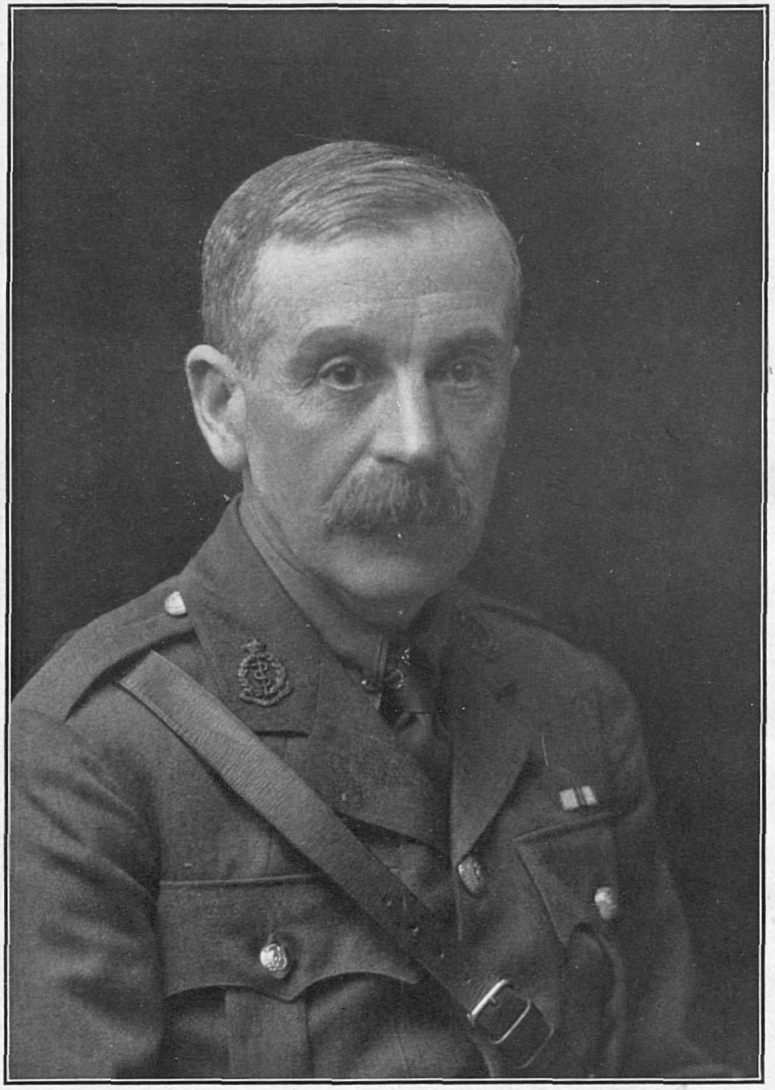
make reports. Let us hope that some of you present are fired with the same enthusiasm as illuminated the members of the Clinical Report Society. Sir Samuel Wilks, when a student, read a paper on Bright's disease which, when expanded, was published in the Guy's Hospital Reports; he always attributed his appointment to the Staff to this paper.

In 1869 Mr. F. G. Larkin, who is happily present with us this evening, read before a very large meeting of the Society, Mr. Cock being in the chair, a paper on Nephrotomy and Excision of the Kidney. A case of renal calculus under the care of Dr. Habershon had set him thinking about operations on the kidney. He demonstrated by operations on rabbits that the kidney could be excised without affecting the health of the animal, that the animals quickly recovered from the operation, and that the remaining kidney hypertrophied. Mr. Cock, from the chair, said that if a suitable case presented itself to him he should not hesitate to operate for stone in the kidney. As you all know, two Guy's men, Mr. Clement Lucas and Sir Henry Morris, were the pioneers of renal surgery, and we may fairly say that modern renal surgery first began at the Guy's Hospital Pupils' Physical Society.

We find that genius Wooldridge in 1876 speaking on the relation of physiology to medicine, and the next year reading a paper on the physiology of the nervous system. About this time were several debates on Listerism. I remember one member showing triumphantly a piece of steak that had been wrapped for a long time in carbolic gauze without undergoing putrefaction. One of the greatest revolutions in medicine has been the introduction of salicylates for rheumatic fever; there were papers and debates on this before the Society. Looking through the old accounts of the Society's meetings, we notice that there were real live debates; thus in the discussion of a paper on typhoid fever twelve speakers took part, and thirteen in one on epilepsy.

This short and imperfect sketch of these two Societies, extending from 1771 to 1919, shows that they have had a wonderful career, of which all members of this hospital may well be proud. They have aided the progress of medicine and have contributed to the medical education of thousands of students. There are two reasons why it is your duty to support the Physical Society by reading papers before it, showing cases, attending its meetings, and speaking at its debates. Firstly, your duty to this Hospital and Medical School; secondly, your duty to yourself.

Your are enrolled as members of a School with great traditions, with a reputation for always advancing medical science, a School at which Bright's disease, Addison's disease, pernicious anæmia, myxœdema, and other diseases have first been differentiated, at which vaccination was welcomed enthusiastically, which was one of the very first in England to adopt Listerism, which was brought to Guy's by Sir Henry Howse, which has produced the best book on medicine ever written, namely, that by Fagge, and which has had among those connected with it many men whose names are famous in every civilised country. The other day I was reading an address by Sir Andrew Macphail; he gives a list of great clinical teachers, almost half of them are Guy's men. Now all these discoverers and teachers were members of the original Guy's Hospital Physical Society or of this Society, its offspring. Your present members have, therefore, inherited a great inheritance, and you must for the sake of the members who have preceded you and for the sake of the Society itself, see that it does not wither under your care; you must so look after it that it continues to be the famous Society that it has been in the past. Do



Sir WILLIAM HALE WHITE, K.B.E., M.D., F.R.C.P.

this earnestly and you will have the pleasant feeling that you, too, are helping your great ancestors; each of you then becomes one of them, insomuch that he also is making the fame of the Guy's Hospital Physical Society.

The secondary reason why you must support this Society is that it is good for your own sakes that you should. It is impossible to exaggerate the clarifying effect of free discussion. Debate a subject and you will find that other speakers let in light on your difficulties and that you illuminate theirs. You will always come away from a good discussion knowing more about a subject than you did before, and you will recognise that you see it in wider and more proportionate perspective. The moment you have to talk about any matter, you are aware of the lacunæ in your knowledge of it, and you will fill them up. You have often heard me say at the bedside that I would sooner you talked to me than that you should remain silent and listen to me, for then I can see your difficulties and, if it lies in my power, remove them. Half an hour's discussion is often more useful than hours of reading or attendance on the sayings of your teacher. Then, too, it is a great asset to learn to speak, for to do so you must arrange your knowledge and arguments in a manner which will make them plain to your hearers; frequently you will discover that, although you think you understand a thing, when you come to speak or write about it you do not. It has been said that a man never really comprehends a subject until he can explain it to others, and this is true. Further, by coming to the Society you can practise the art of speaking. You will gradually be able to get the better of the shyness and nervousness that overcomes the inexperienced speaker when he first rises to address an audience. You will learn to enunciate distinctly and, without shouting, to make yourself heard. Many a time in your life this will stand you in good stead. How pleasant when you have given an address to hear the audience saying after they leave the hall, how interesting, how clearly he put his matter, and how well he spoke; how depressing if your hearers declare that they will never come again, for your speech was a muddle, it was impossible to discern at what you were driving, and your delivery was so tedious that sleep was preferable to listening. In the first instance your speech has done good; in the second, none, and you have wearied your audience and made yourself miserable.

Just as by debating here you can learn to speak, so by reading papers you can learn to write. There are, of course, born speakers and born writers, but they have to practise and are thereby improved. Even if you are not blessed with the gift of doing either readily, your aptitude can be developed by practice. Many hundreds of examination papers have passed through my hands, and often have I wished that the candidates had learnt to marshal their facts and arguments clearly and to make the reading of their answers a pleasure. One of the most melancholy thoughts in the world is to reflect upon the tons of unreadable books, not unreadable because the subject is without interest—indeed, often it has plenty—but unreadable because the matter is muddled and the style makes reading the matter such an infliction, that hardly anyone will undertake it.

Papers by Guy's Men.

S. W. Coffin, Notes on a Case of Viper Poisoning, Indian Medical Gazette, June, 1919.

Arthur Z. C. Cressy, Caesarean Section for Placentia Praevia with concealed Hæmorrhages, B.M.J., November 29th, 1919.

Sir Charters J. Symonds, K.B.E., C.B., Prevention of Venereal Disease, *Lancet*, December 6th, 1919.

R. P. Rowlands, O.B.E., M.S., F.R.C.S., Fracture—Dislocations of the Ankle; Potts and Dupuytren's Fractures, B.M.J., December 6th, 1919.

F. Wyatt Smith, M.B., B.C., Treatment of Delirium Tremens, *ibid.*

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

DEAR SIR,—Dr. Cleveland's letter will have found a ready response in the hearts of most old "clinicals," but nevertheless we are probably all of us ready to echo Dr. Shaw's concluding hope that in the future all the wards will be devoted to medical research—at least if he will allow us to retain our old custom and spell it with a small "r." I would, however, like to point out to Dr. Shaw that the wards at Guy's (not only clinical, but all of them) have always been devoted to research as most of us understand the term, and in suggesting the contrary his letter seems to me to do grave injustice to the memories of a very glorious past. Ever since my knickerbocker days Dr. Shaw has been to me something of an idol, the object of an affectionate veneration which was only deepened during the months when it was my good fortune to be his ward-clerk and house-physician, and I am too steeped in his teaching to believe that he really means any such suggestion as this; but underlying much of his letter there does seem to be the idea that medical research is some new thing that has only recently come to birth and requires some entirely new organisation to enable it to grow. This is a profound mistake; research has been with us ever since the dawn of scientific medicine, and whether one particular ward at any particular time is or is not a place where research is carried on will depend, and always has depended, in the first place on one factor and on one factor only—the man in charge of the ward. If he is a researcher research will be done and the students will be trained in the methods of research; the quality of the training will be in direct proportion to the powers of the chief for research. If the chief is not filled with the true spirit of research, no "adequate resources," no staff and no assistance will avail; nor will it help us if we bring out our capitals and call it a Research Ward.

What do we mean by research? Dr. Shaw gives us his definition; but surely it is inadequate, for it leaves the prefix out of sight; and to the careful observation and record that he demands we must add the critical consideration thereof. The mere search for facts, whether in the child or in the adult without this critical consideration is inquisitiveness rather than research, and these are very different things. I lay great stress on this because I think it goes to the root of the matter. To be able to bring a critical mind to bear on any observations we must in most cases have a fairly wide knowledge of many other facts besides those of our own discovery; we must have a complete acquaintance with all the fallacies that may be involved in our technique, and with the hundred and one pitfalls that lie in wait for the unwary investigator. To acquire this knowledge takes time and labour, and it is generally acknowledged that the only way in which we can hope to surmount our difficulties is to split up our work, to allot to each his sphere and to collaborate. We have therefore now three main groups of workers, and it is essential when we speak of medical research to keep clearly in our minds exactly what type of research we refer to.

First we have those who deal with the sick man at the bedside, whose research is clinical in the strict sense of the word. This group consists of the general practitioners and consultants; secondly there are those who work partly at the bedside but chiefly in the laboratory, and these again are largely concerned with the individual patient; thirdly, we have the group who are engaged in the purely academic pursuit of the knowledge of medicine, dealing with disease qua disease and entirely unconcerned with the individual. Naturally these groups overlap somewhat, and we all of us hope that our work will in the long run help in the progress of medicine.

For most men it will be a sufficiently difficult task to get the necessary training for research in any one of these groups, and certainly it is not least difficult for those in the first and much the largest group with which we may assume we are chiefly concerned in an undergraduate medical school.

One of the most difficult of the problems facing those who are engaged in teaching medicine to-day is how to give those who are to join group 1 a sufficient understanding of the principles underlying the various technical investigations they must call in to their aid to enable them to bring their critical faculty in to play, and yet not to rob them of time that would be better spent in learning the more difficult lessons of the bedside. I know nothing of the "reconstruction" at Guy's, but I gather that Dr. Hurst's energy and enthusiasm have gone far to solve the problem, and his genius for going to the heart of things will enable him to avoid the risk that is inherent in all such clinics of over-teaching and leaving insufficient opportunity for individual observation and responsibility. It would be interesting if Dr. Shaw would elaborate his views in greater detail and tell us in what particulars he finds the conditions in the old "Clinical" incompatible with research in its best and truest sense. We have indeed no need for supermen; we have need of collaboration between those who are efficiently trained in their special sphere, and Mehta's admirable warning was never more needed than it is to-day. "Sutor ne supra crepidam."—I am, yours faithfully,

GORDON W. GOODHART.

24, Warwick Gardens,
Kensington.
December 5th, 1919.

The Student's Share in Educational Reform.

DEAR SIR,—Regarding your "Passim" note on the desirability of a Student's Council, I should, as a former Chairman of the Reconstruction Committee of the Medical School, like to say how much I, and I am sure all the members of my Committee, would have welcomed the assistance of such a council had it existed. I expect we all discussed many of the points of our schemes of reconstruction with the students with whom we were actually working at the time. I am not sure that I did not bore my house physician and clinical assistant by trying to get at their views on administration and educational reform at times when they might have preferred discussions on pathology and therapeutics. At any rate, I was grateful for their assistance, but, valuable as it was, it was not quite the same thing as the considered views of a group of students formed after definite consultation with their colleagues. I therefore wish you all success in your attempt to stimulate the formation of such a consultative body.

By the way, of course you know there is a London University Students' Representative Council. I know it still exists, for in the annual report of an institution just issued I see reference to its meetings. But I am ashamed to say I know nothing of its work. Primarily, I suppose, you would start a Guy's Students' Representative Council with the object of offering advice to the authorities of your own Hospital and School. But it must be remembered that many reforms in medical education depend not on the action of the individual schools, but of the universities and examining bodies for whose degrees and diplomas the students are preparing. A special difficulty for medical education in London is the large number of different universities and colleges to which the students owe allegiance. To effect reform by these august bodies in their requirements for curricula and examinations will need concerted action by the students in many medical schools. For this purpose it would be necessary to forge a link between students' councils in different schools, and it might be desirable to get into touch with the existing London University Students' Council, although this body doubtless deals with other than medical problems.

Have you noticed that at their annual meeting at Cambridge next summer the British Medical Association propose to form a new section for the discussion of Medical Education? This should form an excellent meeting ground for an interchange of views between those who are teaching, those who are being taught, and those who have recently emerged from this second category. If your proposed Council gets together in time, it might send one of its members to read a paper or open a discussion on the Reform of Medical Education from the Student's Point of View.—I am, yours, &c.,

LAURISTON E. SHAW.

Balham Wood,
Herts.

DEAR SIR,—A concert was held at the Coliseum on Sunday, November 30th, in aid of St. Bartholomew's Hospital.

In order to raise as much money as possible several articles were auctioned, and among them were two Teddy Bears. One was bought by "Bart's" for £40, and Guy's bid £25 for the remaining one.

Later funds were asked for by the Middlesex Hospital, and again Guy's helped with one hundred and one shillings.

A collection is being made among the students, and it is hoped all members of the Hospital will assist in raising the money, and thereby abiding by our motto—"Dare Quam Accipere."—Yours faithfully,

GILBERT C. HUGHES.

Guy's Hospital,
London, S.E.1.
December 8th, 1919.

DEAR SIR,—I have read with great pleasure Dr. Lauriston Shaw's thoughtful criticism in your current issue.

My attitude was essentially that of a very "ordinary mortal," severely handicapped by a "faulty education" of the hothouse type, and, incidentally, somewhat flattened out in mind by five years of military service. As such, one realises only too well with Dr. Shaw that educational reform is the primary need of the day, and also, one may add, that the pre-war standard in general must be *restored* before it can be surpassed. It is distressing to view on every hand the feverish attempts which are being made to build ornamental superstructures on foundations rusted through enforced neglect.

I certainly do not regard the vast majority of modern "researchers" as supermen. It is a question of expert technique rather than genius. One man acquires technical ability in surgery, another in medicine, another in chemistry or bacteriology, and at this stage of our knowledge it is unusual for any one so trained to make observations of scientific importance in the field of another, although, given those observations, his deductions may be of equal value.

In these days the unaided observations of the eye or ear are rarely productive of anything really new. Unfortunately for ourselves, the days of Addison and Bright are passed, and it is to the laboratories that we must turn for guidance. Consider the science of physical chemistry, on which the medicine of the future will be based. The most brilliant physician or surgeon attempting to research therein, without the necessary training, is as a child in arms, compared with the man of even average intelligence who has taken the trouble to gain a technical knowledge of his subject. Let the clinician make suggestions to the laboratory worker by all means, and

let him criticise and apply the results; but do not expect him to handle the working tools except as an amateur.

In France the amateur researcher was frequently a positive danger. The least harmful type spent his time discussing a better way, whilst another man got on with the job—and time so often meant lives in those days.

I entirely agree with Dr. Shaw that research is the real basis of a rational education, and to the individual it is ever a source of great personal satisfaction. But what is new to the individual is not necessarily new to science.

MEHTA.

Guy's Hospital,
November 29th, 1919.

DEAR SIR,—In the exceedingly interesting address by Sir William Hale White a reference is made to the gratuity given to Dr. Jenner by Parliament in recognition of his valuable discovery.

May I point out that not only did he get, as stated by Sir W. Hale White, £10,000 in June, 1802, but in 1806 Lord Petly moved that a further grant of £20,000 should be made, which was carried by a majority of 13.—Yours faithfully,

E. CLINESON GREENWOOD.

1, Hanover House,
St. John's Wood, N.W.8.
November 30th, 1919.

Guy's Hospital Physiological Society.

A meeting of the Society was held on December 4th. Mr. Ryffel was in the chair. The minutes of the last meeting were read and confirmed.

Mr. MacKeith read a paper on "Infection and Immunity." He described the process of bacterial infection by secretion of exotoxins which passed into the tissues of the host, and by the accumulation of endotoxins in the bodies of bacteria, these endotoxins being liberated when the bacteria died. To be effective the infecting organism must virulent, must be present in sufficient numbers, and must enter the host by the proper avenue; the host must be "receptive" to this infection.

Immunity was a physiologico-chemical condition of the host by which its invasion by micro-organisms was made impossible or ineffective. Exotoxins were antagonised by "anti-bodies," and the immunity of an animal from these poisons depended on the quantity of "anti-bodies" present before infection, and the subsequent rapidity of production. Endotoxins were dealt with by bacteriolysis, i.e., the bacteria with their harmful contents were dissolved away and broken up. Erlech's side-chain theory with modifications was generally accepted as a satisfactory explanation of the formation of these anti-bodies and lysins. The protoplasmic molecule was supposed to possess a large number of "receptor" processes to certain of which the exotoxins had to attach themselves before they became effective. The attachment of the exotoxins reduced the number of free "receptor" processes, and the molecule to compensate threw out fresh ones, and certain of these processes in excess of the needs of the molecule was thrown off and passed into the tissue fluids as free receptor groups or anti-toxins. In the case of lysins the intervention of a third group was necessary; the enzymic substance, which was to dissolve the bacteria could not gain direct attachment but could be attached to an intermediate group known as an "amboceptor," and this in its turn linked on to a receptor group on the cell which was to be dissolved.

Metchnikoff's theory of phagocytosis explained the defence of an animal against infection as due to the increased activity of their phagocytes which absorbed micro-organisms and destroyed them or manufactured enzymic and antitoxic substances which were liberated on the death of the phagocyte. Wright's observations on the action of phagocytes had shown that phagocytes washed free from body fluids did not exert such a destructive action on bacteria as did blood serum, and this led him to believe in the presence of some "appetising" substance in the blood which he termed an "opsonin"; the power of resistance to bacterial infection was proportional to the quantity of opsonin present, i.e., the opsonic index.

Immunity could be divided into two types, natural and acquired. Examples of the former were seen in mongoose and hedge-hog, which were unharmed by the venom of the snakes they ate. These animals probably owed their immunity to habituation, but every case of natural immunity could not be so explained, as for example the immunity of a cow to glanders. Acquired immunity was developed in the life-time of the individual, and might be the result of infection or of artificial methods such as inoculation. Between these two types of immunity there was an intermediate stage of natural acquired immunity. The case of the South Sea Islanders who centuries ago had had a terrible epidemic of measles and were now immune to the disease was a good example of this condition.

The speaker concluded with a brief history of the artificial methods of acquiring immunity, tracing them from the primitive methods of the Chinese, who treated patients with the scabs of small-pox, then to the methods of the Turks in the Eighteenth Century, when "matter" from small-pox patients was injected into the veins of other people with preven-

titive success, and finally to the more modern discoveries of Jenner and Pasteur.

A discussion then ensued, the chief point being whether natural immunity was not the acquired immunity of past centuries handed down to succeeding generations. Numerous references were made to the recent epidemic of influenza, and it was suggested that the reason why the people chiefly affected were those between 20 and 40 was that the elder ones had lived through the epidemic at the end of the last century, and so had acquired immunity.

Mr. Ryffel considered that the immunity of the South Sea Islanders to measles was a case of the survival of the fittest. The people who had lived through the epidemic were those of strongest constitution, and their descendants would also possess this resistant power. Acquired characteristics were not hereditary, but characteristics which were an essential part of the life of a species were handed down. The immunity of rabbits to belladonna was due to the fact that the danger of eating deadly nightshade was a daily occurrence, so that immunity from its effects was an essential characteristic of the rabbit in its struggle for existence.

One speaker mentioned that in the Services there was an impression that tattooing did away with the need for typhoid inoculation. No suggestion could be made to explain the idea.

The immunity of the domestic fowl to tetanus could be explained by a Darwinian chain of reasoning. Tetanus is associated with highly cultivated soil. Cultivation indicates farming and farms. Farms suggest fowls. So that fowls, pecking about in the soil, would be in daily danger of tetanus infection, so that immunity from tetanus would be an essential characteristic and therefore hereditary.

The immunity of the rat to plague, although infested with the "plague flea," was an example of habituation.

One speaker expressed surprise that modern man could suffer at all from infection if this process of survival of the immune and the destruction of the weak had been going on for so many ages; was it not time that the existing generation was immune from all infectious diseases.

The meeting closed with a hearty vote of thanks to Mr. MacKeith for his paper, and to Mr. Ryffel for his valuable assistance in the discussion.

THE EDITOR will, at all times, be glad to consider Articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Antiquarian Discoveries at Guy's Hospital.

DURING the past few months the western portion of Clinical House containing John Ward has been demolished and excavations beneath and around this site have been instituted, in the progress of which some rather interesting antiquarian discoveries have been made. Clinical House, built in 1744, is often stated to be the oldest part of Guy's Hospital, but Guy's original building, Guy's House, now occupied mainly by the Surgical Wards, is older, having been opened for the admission of patients on January 6th, 1725, only a little more than one week after the founder's death. Clinical House was originally the Lunatic House in which under a curious condition in Guy's will twenty confirmed lunatics were to be accommodated, but this has been in abeyance since 1859 when the Governors of the Hospital took over the building for general hospital purposes, and gave to it its present name. The foundations of Sir Thomas Stephenson's Toxicological Laboratory were removed from the corner nearest the Henriette Raphael Nurses' Home. It was here that Sir Thomas Stephenson carried out his celebrated work, and in it the tests for antimony were performed by Dr. Swithin Taylor and Dr. Owen Reed, which resulted in the execution for murder of William Palmer of Rugeley, a market town in Staffordshire. He was a medical man of dissolute habits, who, having successively poisoned his wife and his brother without suspicion, finally poisoned a man named Cook, and in 1856 became the central figure of one of the most famous criminal trials of the 19th Century.

The completed excavations showed the following order of strata:—

(1) The uppermost layer between four and five feet in thickness was composed of earth containing a large quantity of broken bricks and cement. In it coins belonging mainly to the Georgian era were found.

(2) Beneath this was a layer of about three or four feet in thickness, and containing remains of the Middle Ages.

(3) Indistinctly marked off and merging with the above was a more compact layer of about five feet in thickness composed of humus, and containing Roman remains. Beneath this in the deepest part of the excavation was a layer of untouched earth consisting in its upper three feet or so of clay, and below this again a stratum of sand. It was only in the depth of these excavations that a little surface water began to appear.

PRE-ROMAN REMAINS.

Some fragments of metal were unearthed in the deepest layer, but were so eroded that it could not

be definitely stated whether they were weapons of the ancient Britons or not. A pin of bronze about an inch and a-half in length, having a spiral on each side of the upper end, was found. The spiral is a characteristic of Celtic art, and this article was probably of a date prior or shortly after the Roman occupation of England. This is, I believe, the first known discovery of this type of pin in London, although others have been found in different parts of the country. It differs somewhat from the other type of pin in being shorter than usual and in not being hollow.

Roman Remains.

Remains of the Roman occupation are found in almost every excavation in Southwark, and were unearthed in considerable numbers while the excavations were being made for the Medical Block, and in other parts of Guy's Hospital grounds. So far as I am able to trace no detailed description of these discoveries has been made, so that the following account may be of interest, although it contains nothing of very great antiquarian value.

Coins were found in the Roman layer in fair abundance, and the following is a list of those kindly identified for me by Dr. H. Walter of Stoke-under-Ham, Somerset, and by the Coins and Medals Department of the British Museum.

Coins.

Nerva, Roman Empire (1st Brass and 2nd Brass), A.D. 97.

Hadrian (2nd Brass), A.D. 117 to 138.

Faustina (wife Antoninus Pius), Denarius, A.D. 138 to 141.

(?) Gallienus (or a little later), (3rd Brass), A.D. 253 to 268.

Victorinus, Roman Empire, Britain (3rd Brass), A.D. 265 to 267.

Tetricus, Roman Empire Gaul (3rd Brass), A.D. 268 to 273.

Carausius, Roman Empire, Britain (3rd Brass), A.D. 287 to 293.

Constantine I. as Cæsar, Mint of Lyons (3rd Brass), A.D. 306 to 337.

Constantine II. (1st Brass and 2nd Brass), A.D. 337 to 340.

Constantine Period (several Minimi), 4th Century, A.D.

(To be continued).

Pass List.

Royal College of Surgeons.

Diploma of Fellow—1st Professional Examination, November, 1919.

L. R. Broster.
C. Lambrinudi.
B. L. Laver.
C. H. Medlock.
C. S. Lane Roberts.
F. W. Widgery.

Society of Apothecaries of London.

Final Examination, November, 1919.

Surgery.—R. W. Warrick.
Forensic Medicine.—J. G. Barrie.
Midwifery.—J. Kendall, R. W. Warrick.

Another Case of Anaphylaxis.

The case of anaphylactic shock described in the last instalment of "Leaves from a Medical Note Book" prompts me to quote a similar case from my own note-book.

Captain X—— came to the Clearing Station with a note from his battalion M.O. asking that he might be given a dose of antitetanic serum as he had got a small wound on the thigh just before coming away from the line a day or two earlier. This wound was quite trivial, a mere abrasion of the skin, which did not require a dressing, and did not incapacitate him in the least. I suppose its insignificance did not absolve it from a possible risk of tetanus, but I should certainly not have given the dose of antitoxin if I could have foreseen what would happen. In the case of a more severe wound I should chance the risks of anaphylaxis rather than those of tetanus every time.

Captain X. had never previously had an injection of antitoxin. I gave him 750 units of A.T.S. under the skin, and after a few minutes he set back on foot to his battalion, accompanied by his servant. On the way, about twenty minutes after the injection, he was suddenly taken ill, was scarcely able to breathe, and had to sit down on the roadside. His servant came back for assistance, and he was quickly brought back to the Casualty Clearing Station on a wheel-stretcher, and admitted. I found him conscious and in great distress, with an imperceptible pulse, very rapid and feeble heart beats, his breathing of the asthmatic type, accompanied by loud whistlings and pipings all over the chest. His colour, however, was not bad, which was reassuring. He was put to bed with hot bottles, his clothes loosened but not taken off, and I gave him a hypodermic of morphia and atropine. In half an hour his pulse was countable, his breathing still asthmatic, but he was now chiefly troubled by an urticarial rash over the trunk and limbs which itched intensely. I gave him an antispasmodic mixture, and some local application for the skin, and after forty-eight hours his symptoms had entirely gone, the urticaria being the last to disappear.

On enquiry I found that Captain X. was a "horse-asthmatic." He had had to give up a commission in the Royal Horse Artillery for this reason. As a company commander in the infantry he dreaded the occasions on which he had to ride, as he found

that contact with a horse always brought on an attack of asthma. No doubt some protein of the horse was peculiarly inimical to him. It would have been interesting to know whether a serum from some other animal than the horse would have precipitated the same alarming symptoms.

This was the only case of anaphylaxis I saw in France among, I suppose, some thousands of men who had had injections of antitoxin.

A.N.C.

Reviews, etc.

Dictionary of Treatment, by Sir William Whitla, M.A., M.D., L.L.D., M.P. (Messrs. Ballière, Tindall & Cox, 6th edition, 1920, pp. 1,083, price 25s.).

The sixth edition of this excellent manual has been brought well up to date. The treatment given is sound, and, while new remedies are carefully weighed, those older ones which have proved their value are given their right place. The indications for the adoption of varying lines of treatment are exceedingly well brought out, and no drug is recommended without the reason for its use being given. This book would form a valuable addition to the library of any practitioner, since there can be but few better books of this character published.

The Welfare of the Expectant Mother, by Mary Scharlieb, C.B.E., M.D., M.S. (Messrs. Cassell and Co.'s English Public Health Series), price 5s. net.

This little book is addressed to members of local authorities, midwives, district and other nurses, school teachers, and the large body of health visitors and other helpers in Public Health work. The first chapters deal with healthy and unhealthy pregnancy, and the problems of the training of doctor and midwife is touched upon. In the second half the work of Maternity Centres and Maternity Homes is outlined, and emphasis is laid upon the necessity for State interest in the unmarried mother. The book concludes with useful information upon the Laws and Regulations concerning Maternity Welfare. The conscience of the nation has recently been awakened to the fact that by neglect and ignorance its most valuable assets are being squandered by the annual loss of thousands of its healthy mothers in childbed. Parliament has shown its readiness to pass legislation designed to promote the wellbeing of pregnant women and to ensure their safety in their hour of trial. Local authorities are busy all over the country establishing welfare centres and maternity homes with the help of liberal grants-in-aid. There is a demand for and a need for such a work as this. Though many of Dr. Mary Scharlieb's medical co-workers in the field of social welfare may not accept all the views she expresses or all the remedies she offers, none will question her right to speak with authority on these important matters, and we have no hesitation in giving her book a hearty welcome and a warm recommendation to those for whom it is intended.

Football.

GUY'S v. HARLEQUINS.

The Football Press published our downfall at Twickenham on November 22nd as if some overwhelming catastrophe had overtaken the Hospital. What really happened was that we lost by a single point, and only then by sheer bad luck. A decision went against us, so instead of winning by one goal to one try we lost by two tries to one goal, or six to five against us. There is nothing seriously wrong with the Hospital XV. Guy's men the world over please note. The present team is one of the best of recent years, but all teams have their "off" day. Saturday, November 22nd, was not our "on" day. I am not excusing our defeat, simply stating facts. The conditions were heavier than we have been used to. It was a day for forwards, and the Harlequins knew this well enough. Their pack set out to prevent our backs getting the ball, to rush and bustle us off our game, and they succeeded to the tune given above. The critics say we were disappointing, the three-quarters stood too far off each other and their passing was slow. Another writer says he had not seen Guy's before this season, and from their showing in this match he would almost think their high scoring in matches against weaker sides has given them a too high reputation for strength and skill. I would refer the gentleman to our wins over Oxford and the Services, and to our game against Cambridge. Stiff games all three, and the results are not such, I think, to damage even the reputation of Guy's First XV.

There was no scoring in the first half, and very little but ding dong play of a highly exciting character. One side was out at least to score at any cost, and we were put to it somewhat severely to keep our lines intact. Once Krige had a shot at dropping a goal, and Van Schalkwijk looked like scoring, but he hung on too long.

Steyn got under weigh early in the second half, but something went wrong. The Harlequins replied, and Millett brought off a good tackle and averted a try. Birkett, however, got away soon after, and with Hudson handing on from Birket to V. G. Davies, the last-named scored. Soon after Birkett was through again. Neither try was goaled. Our

men renewed their efforts after this, and Van Schalkwijk dodged through for Millett to goal. The last two minutes were very full of excitement, but no further score came to either side. Guy's team:—

H. Millett, G. L. Steyn, P. J. Krige, H. G. Davies, J. Van Nickert, F. Bekker, G. Van Schalkwijk, W. D. Doherty, F. W. Reitz, A. Marais, A. H. Shellswell, G. R. Aspinwall, E. Neser, B. F. H. Duncan, and G. Zondagh.

Change of Address.

Miss M. C. Bennett, Brooklyn Nursing Home, 321, Upper Richmond Road, Putney, S.W. (Tel. Putney 1603).

Capt. G. F. H. Bloom, Royal Air Station, Bircham Newton, Kings Lynn.

H. Cardin, 33, Woodbourne Avenue, Streatham, S.W.16.

Capt. F. K. Escritt, R.A.M.C., 14 Stationary Hospital, Boulogne.

A. R. F. Evershed, Southridge, Overbury Road, Parkstone, Dorset.

Sister G. A. Fuller, from The Training School, Guy's Hospital, to Brooklyn Nursing Home, 321, Upper Richmond Road, Putney, S.W. (Tel. Putney 1603).

F. G. Lloyd, F.R.C.S., 1, Sinclair Road, West Kensington, W.

Capt. J. Birch Martin, R.A.M.C., from Royal Victoria Hospital to 1, Morris Road, The Polygon, Southampton.

Surg. Rear Admiral Sir William Pryn, K.B.E., C.B., Yeoland, Yelverton, South Devon.

Capt. W. R. Ransford, Westdene, Stoke Bishop, near Bristol.

Miss Margaret A. Robertson, 26, Cleveland Gardens, Hyde Park, W.2. (Tel. Padd. 3350).

Notice.

CHARLES MURCHISON SCHOLARSHIP IN CLINICAL MEDICINE.

The next examination for this Scholarship will be held at the Royal College of Physicians of London on Monday, the 14th day of June, 1920, and following days.

The examination is open to any student of medicine, whether holding a medical qualification or not, who, subsequently to the date of passing his professional examination in anatomy and physiology for a medical qualification, has studied for a period of not less than two and a-half, and not more than five, years at a Medical School in London, recognised by the Royal College of Physicians, or at the University of Edinburgh, including Medical Classes recognised by the Medical Faculty of the University.

The examination will be conducted both orally and in writing, and will include:—(a) Examination of patients, with reports on their cases (b) questions on pathology and treatment, and (c) examination on specimens.

The Scholarship is of the value of Twenty Guineas, and is tenable for one year.

Intending candidates are required to send in their names to the Registrar of the Royal College of Physicians, Pall Mall East, London, not later than June 1st, with evidence of the duration of the medical studies from the Deans of their respective Schools, and evidence of the date at which they passed their examination in anatomy and physiology.

The examination for 1921 will be held in the University of Edinburgh.

J. A. ORMEROD, M.D.,
Registrar.

Birth.

ALLEN.—On November 23rd, at Ebor House, St. John's Park, Blackheath, to the wife of T. S. Allen, Captain, R.A.M.C., a daughter.

Marriages.

MARTIN—BUNN.—On November 11th, at St. Luke's Church, Maidenhead, by the Rev. H. A. Thurland, John Birch Martin to Edith Hilda, youngest daughter of S. C. Bunn and Mrs. Bunn, of Furze Platt, Maidenhead.

ROBERTS—WEST.—On the 7th November, at St. Paul's, Covent Garden, by the Rev. A. Monks, Herbert Charles Roberts (late H.A.C. and R.A.F.), youngest son of the late Henry Roberts, of Upper Clapton, and Henllan, North Wales, to Marjorie Beatrice West, only daughter of the late Stephen West, of Croydon, Surrey.

Deaths.

EVERSHED.—On November 17th, at Fishbourne, near Chichester, Arthur Evershed, M.R.C.S.Lond., in his 84th year.

HOLMAN.—On December 1st, 1919, Edith Sybilla, the loyal and beloved wife of R. Colgate Holman, M.R.C.S.(Eng.), of Midhurst, Sussex, after a prolonged and distressing illness.

ED.—J. V. C. B.

GUY'S HOSPITAL GAZETTE.

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Passim.

BY the time this issue appears Christmas will be over, and we shall once more be applying ourselves to our daily tasks in the normal way, strengthened and refreshed, we trust, by this cheerful interlude. Everyone at Guy's has his time very fully occupied during this season, and wielders of the editorial pen are by no means exempt! Therefore we ask our readers' pardon for a somewhat thin GAZETTE.

OUR heartiest congratulations to Mr. E. G. Slesinger on obtaining the University Gold Medal at the recent M.S. examination at the University of London. Everyone who knows the Hospital will be greatly pleased at his well-deserved success. This, coupled with Dr. Ryle's Medal in the M.D. examination, forms a proud record for the Hospital for the past year.

IT is a matter for congratulation that, whilst shortly losing the services of Sir Cooper Perry as Superintendent, the Hospital will still have the advantage of his advice and assistance in his capacity as a Governor of the Corporation, having been elected to that body at the last meeting of the General Court.

At the same Court it was unanimously resolved, that, consequent upon the resignation of Sir Cooper Perry on his appointment as Principal Officer to the University of London, to take effect on January 31st next, the appointment of Superintendent of the Hospital be offered to Mr. H. L .Eason, C.B., C.M.G., M.D., M.S.

THE news of the appointment of Mr. Eason as Superintendent is widely known by this time. Of the future "Super's" life work a worthier pen has written on another page. May we take this opportunity of expressing to him the good wishes of the whole Hospital when he starts his new duties.

THE recent announcement in the press of an anonymous gift to the Hospital of £20,000 is a notable example of charity. The sum is, we believe, the largest single donation ever received by the Hospital, and it is so completely anonymous that even the "highest official circles" are quite in the dark as to the identity of the donor. A splendid lead is thus given towards meeting the large new claims on the Hospital, and we hope it will be splendidly followed.

CONGRATULATIONS to Messrs. Krige and Millett on their being picked to play for the South in the recent trial matches, and to Mr. Bekker on being chosen reserve for the same side.

IN spite of the letter of our anonymous correspondent, which appears on another page, we are pleased to see that our sprightly little contemporary, the "Guyoscope," has taken a new lease of life. We personally believe that at Guy's good-natured fun is, and always will be, taken in the spirit that it was given, and that members of the staff will be rather proud than offended at having themselves "taken off" in its columns. For it is a strange fact about human nature that whom it loves it ridicules, and that there is no surer sign of the popularity of a teacher than caricature in prose, verse, or art by his pupils. And so we wish the "Guyoscope" every success in its struggle for existence.

We have been requested to state, for the benefit of old Guy's men, that they may obtain copies from the Librarian, on forwarding 1s. 1½d.

IN the new appointment of Clerk in the Neurological and Children's Department, the physicians' times of attendance clash. Therefore in future Dr. Cameron will attend on Mondays and Fridays, and will go round Miriam on Tuesdays, while Dr. Hurst will attend on Wednesdays and Saturdays, and will go round the neurological beds on Fridays. Also men will be able to do vaccinations, fevers, or anæsthetics during this appointment, always provided that these will not prevent them from attending their physicians on their respective days.

IT has been pointed out that many men hold the appointment of Extern long before they can go up for their examination in midwifery. In future this appointment will be held after they have had three months in the Children's Department. This arrangement will have many advantages, not the least of which will be the knowledge of infant feeding that the student will have gained before having the responsibility of determining the manner of the rearing of the infant on his shoulders. The mother of nine is rather terrifying to the extern when she talks about babies, and such time-worn phrases as "never could nurse my babies" or "the milk has dried up" are apt to carry too much weight with the worried and over-anxious obstetric student. We need have no fear of this, however, if he has spent three months in the Children's Department, and learnt how often these are either mere excuses for laziness or expressions of ignorance on the part of the mother.

IN the case of medical students, who are also dental students, the appointment of Clerk in the Children's Department will not be compulsory. Instead of this these men will be required to spend three months as dressers in the throat and ear department.

AT Guy's we are fortunate in having some of the finest clinical material in the world passing through the hospital. But it often happens in the urgent surgical cases that the patient is operated on before anyone other than the take-in firm knows of its admission. Everyone who has been a year or so in the wards will no doubt remember one or more extremely interesting operations which he did not see because he was unaware of their being performed. It is most regrettable from every point of view that this should occur. It has

been suggested, therefore, that some sign in the college, such as a coloured light, should be shown whenever any operation of great interest is proceeding. This would not cost much, and we are convinced that it would be most effective.

On January 8th, at 4.30 p.m., a general meeting of the Physical Society will be held to discuss private business. It is earnestly hoped that all members will make a special effort to be present. After Sir William Hale White's inspiring and eloquent address, every member of the Physical Society will be very keen to uphold its traditions, and to ensure its success for the coming year. Therefore every man in the wards, if he can be spared, should come to the meeting, as matters of very great importance to the Society will be discussed.

The Clubs' Union Year Book is now published. Life members will receive a copy on application to the Gazette Office, Guy's Hospital, S.E.1.

The College Library has now been catalogued. It will be open on and after January 1st, 1920, at the following hours, every day except Saturday and Sunday:—1.30 p.m. to 2 p.m.; 5 p.m. to 5.30 p.m.

Sir W. Arbuthnot Lane paid a visit to Guy's on the afternoon of December 22nd, and performed three operations—Plating a supracondylar fracture, cleft palate and hare lip, and laparatomy. The theatre was full of spectators, among whom were the following ex-House Surgeons of Sir Arbuthnot:—Messrs. Steward, Fagge, Chapple, Mullally, Slesinger, Tanner, "Sam" Wilson (who was in London on a few days' leave), and Joffé.

Guy's Hospital.

PROPOSED TIME-TABLE FOR OUT-PATIENT AND IN-PATIENT ATTENDANCES OF MEDICAL AND SURGICAL UNITS AND OF OUT-PATIENT ATTENDANCES IN THE SPECIAL DEPARTMENTS.

Monday.

At 9 a.m.—Dr. Mutch (Medical O.P.'s); Mr. Hughes (Surgical O.P.'s); Dr. Cameron (Children O.P.'s).

Before 12 noon.—Mr. Chapple (Gyn. O.P.'s); Mr. Ormond (Eye O.P.'s); Mr. Layton (Thr. O.P.'s); Mr. Trethowan (Orth. O.P.'s).

Tuesday.

At 9 a.m.—Dr. Hunt (Medical O.P.'s); Mr. Bromley (Surgical O.P.'s).

Before 12 noon.—Dr. Barber (Sk. O.P.'s); Mr. Eason (Eye O.P.'s); Mr. Mollison (Thr. O.P.'s); Dr. Marshall (Tub. O.P.'s).

Wednesday.

At 9 a.m.—Dr. Cameron (Children O.P.'s); Medical Out-Patients; Surgical Out-Patients; Drs. Hurst and Craig (Neur-Psych. O.P.'s); Mr. Thompson (G. U. O.P.'s).

Before 12 noon.—Mr. Trethowan (Orth. O.P.'s); Mrs. Vaughan (V. O.P.'s).

Thursday.

At 9 a.m.—Dr. Cameron (Medical O.P.'s); Mr. Turner (Surgical O.P.'s); Dr. Barber (Sk. O.P.'s).

Before 12 noon.—Mr. B. Smith (Gyn. O.P.'s); Mr. Ormond (Eye O.P.'s); Mr. Layton (Thr. O.P.'s).

Friday.

At 9 a.m.—Dr. Poulton (Medical O.P.'s); Mr. Davies-Colley (Surgical O.P.'s); Dr. Cameron (Children O.P.'s).

Before 12 noon.—Mr. Eason (Eye O.P.'s); Mr. Mollison (Thr. O.P.'s); Dr. Marshall (Tub. O.P.'s).

Saturday.

At 9 a.m.—Medical Out-Patients; Surgical Out-Patients; Asst. Neurologist (O.P.'s); Mr. Thompson (G. U. O.P.'s).

Evening Out-Patients.

Mondays, Male V.D.; Wednesdays, Tuberculosis; Thursdays, Male V.D.

Sir Cooper Perry's Successor.

The new Superintendent, who was born in 1874, came up to Guy's from University College as a University of London student, and took his M.B. in October, 1899. When a student he was known as a cheery mortal, and joined that happy band which originated and ran the first "Guyoscope." The syndicate which is reputed to control the third "Guyoscope" will have to work hard to attain that which the second "Guyoscope" barely succeeded in doing, to equal the original venture. He also was a leading light among the Dis-Guysed Minstrels, a band who are to the Christmas Day Niggers what the performers of Italian comedy were to our friends of the streets, Mr. Punch and his Judy. In his more serious moments Mr. Eason managed to edit the Gazette what time he was doing dresser and extension dresser to Mr. Clement Lucas and A.H.S. to Mr. Jacobson. In his first number on May 21st, 1898, it fell to his duty to chronicle the death of our Senior Governor, Mr. Gladstone, and he carried on with the work till he was appointed to Dr. Fredk. Taylor as H.P. in January, 1900.

In December, 1901, he took his M.D.Lond., and a year later his M.S. In the meantime he had become ophthalmic assistant to Mr. Brailey, and in 1902 started his administrative career as Warden of the College. In 1904 a new precedent was constituted by his being made Dean of the Medical School before he became a member of the staff. This followed in the fall of 1905, when he succeeded Mr. Brailey as Ophthalmic Surgeon.

As Dean that rapid working of his brain which is one of his most striking characteristics stood him in good stead. Many a committee man has seen him busy with a pencil and has then voted for some resolution drawn up *currante calamo* which has picked out the good points of a rambling discussion and steered clear of dangerous ones upon which the committee would inevitably have come to grief. A slow-thinking member of the Junior Staff has been known to ponder some problem deeply for weeks and then to meet the Dean on the steps of the Medical School Office while on his way to put it before him; to have his description taken out of his mouth completed, criticised, knocked down and set up again, and to be told the thing should be put before the School before, with long rapid strides, the pair had reached the colonnade. To some his rapidity suggested superficiality until a further acquaintance proved that it indicated rather a lightning power of receiving, arranging, and acting on the facts put forward.

In 1912 he was elected to the Senate of the University of London, where his work favourably impressed his elder colleagues from the other medical schools. From this he retired in 1915 without completing his term of office, and we may put forward the hope, in passing, that he will regain his seat on the Senate at the coming election in the Faculty of Medicine. The cause of his retirement was his appointment as Consulting Ophthalmologist to the Forces in the Mediterranean in Septem-

ber, 1915, and he arrived at Mudros in October of that year. After the evacuation of the Peninsular he returned to Egypt in the same capacity to the Egyptian Expeditionary Force and in which he remained till his return to this country in July, 1919. For these duties he was given the C.M.G. in 1917.

Former experiences of war in the East, notably the campaign of Napoleon, had led the D.G.A.M.S. to fear a serious amount of eye disease. The precautions taken prevented such a thing, and when history has had time to review the subject as a whole we believe that this freedom from ophthalmia of our troops in the East will prove one of the most forceful examples which the war has given us of the value of preventive medicine as a whole and of field sanitation in particular.

In the middle of 1917 the man-power question in Egypt was acute. Only "B" Class men were being sent out from England, and the Mediterranean did not afford a healthy voyage for these; next to no sick and wounded could be sent home, and even these had on occasion to travel via the Cape of Good Hope. At the same time there was a need of more divisions for the advance into Palestine. A rigid comb out of all line of communication and base units was made against an enormous amount of opposition to the Adjutant-General's branch of the Staff, on whom the duty devolved. This could never have successfully been done unless some organisation had provided a uniform system of medical boards and had stopped any amount of attempts at "wangling." Such an organisation was set up by Colonel (now Sir James) Barrett and Mr. (then Lieut.-Col.) Eason, who were appointed Presidents of the Standing Medical Boards for Classification and Invaliding in Cairo and Alexandria respectively. Their function was to supply as many men as possible for the line in a country where physical fitness was more necessary than on any other front, to stop the continual drifting of cases that should never have been evacuated along a line of communication which by its length and the ground over which it ran was taxed to the utmost, and generally to stiffen the backs of the medical services against the malingerer, the valetudinarian and the officer, commanding or otherwise, who wished to get rid of an undesirable junior N.C.O. or man by suggesting he was sick.

At the same time Mr. Eason was President of the Special Medical Board to the Flying Corps from September, 1917. Both these appointments, for which he was made a C.B. in January, 1919, he held until forced to give them up by his ophthalmic work again needing all his energy. The cause of this was an outbreak of ophthalmia among those Turks, prisoners who in twenty-four hours had been changed from an army in being to a number of isolated stragglers by Allenby's victory of September 19th, 1918, and had been made prisoners in the following weeks.

We believe there is no record in ophthalmological literature of any outbreak so appalling in its rapidity and its severity as this was, and we are glad to say that an account of it will appear from Mr. Eason's pen in the War Memorial Number of the Guy's Hospital Reports.

Inguinal Hernia. The Imperfectly Descended Testicle and Varicocele.

By P. TURNER.

pp. 104. (Messrs. J. & A. Churchill).

In this short book the author has described his contributions to the surgery of the testes. The first chapter gives a good account of the ordinary operation for Inguinal Hernia performed without division of the external inguinal ring. Whether the importance attached by the author to this structure has not been over estimated is indeed a matter of opinion. At the same time, from the theoretical considerations with which this chapter opens, it may be well understood that an occasional recurrence of hernia might be explained on the weakness of the external oblique following the division of its insertion into the pillars of the ring, although even here an actual demonstration would be impossible. The share of the external oblique in the prevention of post operative recurrence of inguinal hernia seems to be exaggerated at the expense of the internal, which after all is muscular in this region, and one might imagine of more value in the prevention of displacement than a mere mass of fibrous non-contractile tissue. We find the second portion of the volume altogether more refreshing.

After an excellent account of the anatomy and physiology of the undescended testicle—excellent because of the well-weighed presentation of the facts without any unjustifiable dogmatic deductions—we read a most lucid account of the author's operation for transposition of an undescended testicle to the opposite side of the scrotum. It is a little difficult at the moment to assess the value of the operation because of the dearth of statistics. The author modestly estimates the probability of improvement at 50 per cent., so that there is every hope that the sphere of the operation will become extended for the complaint is after all a very common one without any conservative treatment worth mentioning at the present time.

The author's very neat modification of the usual operation for varicocele forms the third section of the book. Here again the exigencies of war have prevented the author from estimating the after results of his method of elevating the testicle on the diseased side; from the theoretical side it is impossible to state any a priori objection to his plastic method of making the coverings of the cord fashion as a testicular sling.

The publishers are to be congratulated for the excellent pictures which illustrate the book, and for the absence of any printers' errors. We have much pleasure in recommending this volume to all senior students and house men.

Specialities.

Messrs. Eucryl, Limited, 34, Lant Street, Southwark, S.E.1.

That the importance of dental hygiene as the basis of general health is now widely recognised, is shown by the large number of dentifrices offered to the public to-day.

Many of them are excellent for their purpose, and Eucryl Tooth Powder and Tooth Paste may be particularly mentioned as an effective cleanser and disinfectant for the mouth and teeth.

It has a pleasant flavour, yet at the same time is free from any injurious acids.

Its price, too, is very moderate.

THE EDITOR will, at all times, be glad to consider articles or sketches, provided that they are accompanied by the writer's name and address, not necessarily for publication. The payment that the GAZETTE *can offer is merely nominal. Authors who desire reprints of their papers should make their own arrangements with the printers when they return their proofs. All contributions to be addressed to the Editor, "Guy's Hospital Gazette," Guy's Hospital, London, S.E.*

Leaves from a Medical Note Book

(1914—1918).

IX. Some Cases of "Shell-shock" in the Early Phase.

It is a matter for regret that so few observations by regimental medical officers of the early stages, both of commotional and emotional shock, have been recorded. Undoubtedly the difficulties were extreme, and no encouragement was given to the collection of such records by the authorities or by investigators behind the line, but a valuable link might have been added to the chain had we better information as to the preliminary histories, symptoms and signs in the many types of affliction which have been grouped under the heading of "Shell-shock."

The following very brief and incomplete notes are only early in the sense that they describe cases admitted to a Casualty Clearing Station within a few hours of the onset of symptoms. They do not record the immediately initial phase.

Case 1.—Gunner H., æt. 19, was admitted April 17th, 1916, in good condition physically, but showed loss of speech, tachycardia, and involuntary twitchings of a choréiform type. Attempts at speech only resulted in facial contortions. He gave a written history to the effect that a shell had burst close to him three weeks previously, and that a few days previously aeroplanes had dropped bombs near to his billet. Stuttering which followed the first incident gave place to speechlessness after the second. He showed great hypersensitiveness to the smallest stimuli, and jerks were all increased, but he had no signs of an organic lesion. April 19th: Col. Myer saw patient, and tried to induce hypnosis. He also trained him in the production of sounds with some success, and gave a good prognosis. April 20th: Patient is improving, and with encouragement can be got to read slowly and in a whisper, though there is still much stammering and facial twitching. He is a very good subject. The night orderly reported that he had spoken in his sleep, and the patient was much cheered. Eats and sleeps well; is on small doses of bromide. No evidence of hyperthyroidism. Sent to Base.

Case 2.—Private R., 8th Bedfords.—Apparently quite unconscious and unresponsive on admission, with retention of urine and simultaneous spasmodic jerks of lower limbs, which are apparently painful, and suggest strychnine spasms. When taken to the theatre patient sat up and spoke, and during induction of anæsthesia shouted quite coherently. Lumbar puncture gave clear fluid at a rate suggesting increased pressure. After return to ward jerks returned and catheterization was again necessary. Next day patient wrote the following statement:—"We was called out in support of the 8th Bedfords, as they had lost a trench; we was going across La Bricque communication trench when the Germans saw us and shelled us terrible. I was in the trench at once, and the shell that as made me like this killed five of my pals. I remember a sandbag falling across my back as I was flung to the ground by the explosion. I don't know what happened afterwards or where I was until I came to in this hospital. I suppose the old regiment is cut up by now. I think the reason I cannot speak is through the sudden shock I got through a big howitzer shell bursting quite near me, and I have a slight sharp pain in my stomach when I try to speak." The reflexes were normal, and there was no anæsthesia or hyperæsthesia. Patient ate and slept well. An attempt at cure by suggestion under light anæsthesia induced a raving, fighting ex-

citement. Patient was evacuated better generally but still speechless.

Case 1 suggests the emotional type. In Case 2 the loss of memory after physical concussion, the retention of urine, and the possibly increased pressure of the cerebro-spinal fluid suggest that there may have been a transient organic basis for the symptoms, though their persistence was almost certainly functional.

In the remaining four cases no history was obtained, and except as instances of different types of symptomatology they are of small interest.

Case 3.—Canadian Infantryman.—Admitted in a torpid, unresponsive state, limp and anæsthetic; reflexes sluggish; retention of urine; speechless; depressed facies. Temperature normal. Cerebro-spinal fluid clear and "under moderate pressure." Slight improvement during next two days, but bombs dropped round the hospital brought on acute symptoms; patient tried to get out of bed and had to be given morphia.

Case 4.—Canadian.—Admitted in a torpid, unresponsive state, suggesting concussion, but moves about in bed. Tremulous eyelids; incontinence of urine with retention later. Knee jerks present; plantar reflexes flexor. Temperature normal. Cerebro-spinal fluid clear and under ordinary pressure. During the next few days patient improved, became more alert, and made movements with his lips, and also regained control of his bladder.

Case 5.—Canadian.—Admitted with loss of speech and hearing and general flaccidity. Reflexes normal. Slow pulse, but not a compression pulse. Anæsthetic everywhere to pin pricks. Arms remain in whatever position they are placed. Micturition normal.

Case 6.—A Sergeant of Canadians.—A big muscular man, was admitted in a state of extreme and restive terror, hearing shells in every sound, and cowering when taken out in the open air in fear of hostile aeroplanes, though none were about and there was no firing. He was put to bed and given $\frac{1}{4}$ gr. Morph. hypodermically and xx gr. Pot. Brom. The next day he was quite quiet, and only slightly tremulous, but rather depressed.

Ordinary cases of mutism responded readily to stimulation under light anæsthesia. In three years of casualty clearing station and ambulance work only one wounded man was seen with "shell-shock" symptoms.

The lumbar punctures in the above instances were performed with a view to discovering possible evidence of physical concussion.

In direct concussion and fractured base, a fine suspension of red cells is sometimes seen in the cerebro-spinal fluid.

(*To be continued.*)

Guy's Hospital Physiological Society.

A meeting of the Society was held on Friday, December 12th. Dr. Hurst took the chair.

Mr. Apsey read a paper on "Hypnotism." He gave a brief history of the science or art of psychotherapy as practised by priests and monarchs in the past ages, and traced its development up to the methods of the present time.

Paracelsus thought this healing was produced through the influence of the heavenly bodies, while the celebrated Frederick Mesmer attributed it to a magnetic fluid which pervaded the universe, and he believed that by making passes with the hands this fluid could be brought to bear upon the seat of the disease. James Braid proved that he could produce all Mesmer's phenomena by concentrating the patient's attention on a fixed light, thus showing that the hypnotic state which resulted was entirely dependent on the mind of the patient. The hypothesis of the dual functioning of the mind finally gave a satisfactory explanation of the results—all

human beings possessed a conscious and a subconscious mind, and in hypnotism the conscious mind was attracted away, leaving the subconscious mind open to suggestion.

Examples of the working of the subconscious mind could be seen in such movements as dancing or cycling, which were performed without any conscious effort, yet were not reflexes. The writing of the "planchette" was the expression by the subconscious mind of suggestions which it had previously received although these suggestions would be quite unknown to the conscious individual.

Various methods for producing the hypnotic condition were used. Braid made the subject stare at his polished lancet case; Lesdail placed the patient in a dark room, made passes and breathed on his eyes and head; while others used strong lights, soft music, dark rooms or galvanism. All these methods were generally accompanied by whispered suggestion, such as "You are feeling drowsy—your eyelids are heavy—you are going to sleep," etc. The termination of the hypnotic sleep was produced by suggestion from the hypnotist or by mechanical means such as rubbing the eyelids or putting cold articles upon the patient's face—apart from these methods the patient would wake within three hours of the cessation of the hypnotic influence.

Sleep and the hypnotic state differed in several ways, especially as regards dreams. These were internal in origin, and far more complex than the hypnotic hallucinations produced from without by suggestion. Amnesia or loss of memory was a characteristic of both states. The hypnotised patient would not accept any suggestion contrary to his moral convictions or principles.

Waking suggestion was a convenient but slow method of dealing with patients who objected to hypnotism; its effects were not very lasting. Auto-suggestion—a method in which the patient himself persuades his subconscious mind by his own repeated suggestions—was a method which did away with the objection that the influence or character of the hypnotist might affect the patient. These suggestions need not necessarily be true, but they should be devised to lead in the direction of improvement, and after constant reiteration they would become true.

The subconscious mind was unable to tell whether a suggestion was true or not, logical or otherwise—it could only accept or reject, and if accepted it could make logical deductions. If a hypnotised man were told he was made of glass he would accept the fact and act accordingly; he would step gingerly to avoid breaking, and would not go too near a fire for fear of melting.

Hypnotism could be used to relieve pain or as an anæsthetic in dentistry; although the pain was removed it was to be borne in mind that the cause of the pain still remained, and it was in questions of this kind where the pain was an indicator of organic disease that Christian Scientists and the so-called "healers" failed because they could not recognise and treat the real root of the disorder.

Psycho-analysis was another branch of psycho-therapy; its improving effect depended on the removal of impressions of past occurrences which were upsetting the patient. Usually the patient had experienced some painful accident or emotion and had tried to repress the thought of it; the resulting struggle between the subconscious mind and this emotion showed itself in some obsession or neurotic outburst. By encouraging the patient to talk of the event, relief could be given and improving suggestions made.

The speaker closed with a short résumé of the diseases which could be successfully treated by methods of suggestion.

The meeting was then thrown open to discussion. Dr. Hurst pointed out the difference between hypnotism and suggestion, and stated that the former was not resorted to as much nowadays as it was a few years ago. This was because it was found in cases where hypnotism had been tried and had failed, all other forms of treatment were made increasedly difficult. Hypnotism was not such an unusual thing as people imagined. Babies were hypnotised to sleep by their mothers; the congregation passed into a hypnotic state under the influence of the parson in his sermon. Suggestion was not an essential companion of hypnotism, as blind and deaf soldiers had been successfully hypnotised. In like manner "suggestion treatment" was quite an everyday occurrence—the doctor's "bedside manner," the bonesetter with his bloodless operations, the pilgrimages to Lourdes and other famous shrines were instances of the use of suggestion. Psycho-analysis was most effective with educated people; it was merely explanation aided by suggestion and re-education. Dr. Hurst then gave some very interesting examples of hypnotic and suggestive treatment in cases he had dealt with personally, and also gave a brief sketch of the various ailments in which these methods were effective. He pointed out that no improvement could result in cases of organic disease except, as a subsequent speaker pointed out, the removal of the super-imposed hysterical symptoms.

One speaker spoke strongly in favour of the inclusion of a course of practical psychology in the medical students' syllabus, but another member thought that as a large number of students were "highly-strung" the efforts of hypnotism might tend to make them neurotic. Dr. Hurst stated that the

idea that a hypnotist must have a strong will was a fallacy; he did not think it required any great mental effort. Further, the idea that the patient remained perpetually under the influence of the hypnotist was ungrounded. There was no such thing as "after-influence."

Unfortunately the meeting had to be closed at this point, as the chairman had to leave; but it is hoped that a continuation of the discussion can be arranged. Dr. Hurst very kindly promised to arrange a demonstration of hypnotic methods for the Society, and the meeting closed with a very hearty vote of thanks to him for taking the chair.

University of London Officers Training Corps.

Report on the Future of the Officers Training Corps adopted at a Conference of past and present Officers of the Combatant Units of the University of London O.T.C.

Note.—The Conference was held at Headquarters, 46, Russell Square, on Wednesday, October 15, 1919. Major Sir Edward Busk, Chairman of the Military Education Committee, presided.

Officers of the combatant units who were on the strength at the outbreak of War and officers who joined the Contingent after the outbreak of War and served with the Contingent for at least one year during the War were invited to attend.

The following officers were present:—Lieut.-Cols. Charles and Richardson, D.S.O.; Majors Atkinson, Courtman, Filon, and Hill; Capts. Chandler, Holt-Hughes, Humberstone, Newcombe, and Sinnatt, M.C.; Lieuts. Browning and Wall.

The following officers were invited but were unable to attend owing to absence abroad or other reasons:—Lieut.-Col. Capper; Majors Harris, Robinson, M.B.E., and Thomas, D.S.O.; Capts. Cameron, Dibdin, M.C., Egerton, Martin Smith, Page, M.B.E., and Slade, M.C.; Lieuts. Acland, Claudet, Curnock, MacAlister, Ridge, Scott, Smith, and Wilkinson; 2nd Lieuts. O'Donoghue, Orr, and Wright.

The Adjutant of the University of London O.T.C., Capt. H. Peploe, D.S.O., Royal West Kent Regt., attended by special invitation.

The object of the following Report is to discuss the question of the future of the Officers Training Corps in relation to the experience gained during the War and to submit recommendations.

Work of the Contingent for the War.

About 200 cadets of the University of London O.T.C. had been granted commissions in the Army and Navy before the outbreak of War. A much larger number of trained and partially trained cadets proceeded to commissions immediately on the outbreak of War and during the first few months of the War. It is believed that these officers rendered specially valuable service, both on active service abroad and in training recruits at home. The combatant units of the Contingent were actually under canvas in camp immediately before mobilisation was ordered, and there was, therefore, no delay in forwarding the applications of those cadets who were present in camp and were considered suitable for commissions. As regards other cadets who had received training in the Contingent, there was unavoidable delay in forwarding the applications. It is regrettable that no steps had been taken before the War to ascertain the names of cadets and ex-cadets willing to come forward for commissions in a national emergency. Proposals on this matter which were submitted to the War Office some months before the outbreak of War were rejected on the ground that any action in this direction would impede the natural flow to commissions in the Special Reserve. The number of cadets and ex-cadets who proceeded to commissions before the outbreak of War was 204; to the end of 1914, 1,085; to the end of 1915, 2,300; to the end of 1916, 3,082; to the end of 1917, 3,753; to the Armistice, 4,133. Including officers and ex-officers of the Contingent, the total contribution of the Contingent to the War is estimated at 4,201 officers. These officers have gained 1,524 distinctions in the War, including five V.C.'s, 52 D.S.O.'s and bars, and 582 M.C.'s and bars. 630 of these officers have fallen in the War. During the periods August-September, 1914, and April, 1915, to February, 1916, a School of Instruction for officers was conducted by the Contingent at Headley, South Harrow, Perivale and Hertford, and 900 officers passed through the School. In addition a number of officers of the Canadian R.E. were attached to the Engineer Unit for special training. There is a general feeling that the work of this and other Contingents before and during the War has not been officially recognised, e.g., in ministerial statements in Parliament. It may be mentioned that the University of London O.T.C., which has trained an appreciable proportion of the officers who have served in the War, was not represented in the march-past of the London troops; nor were any places offered to the O.T.C. generally in the official Peace celebrations. This is the more inexplicable, seeing that in 1911 the O.T.C. was given generous representation at the King's Coronation. The question of recognition may appear to be relatively unimportant, but it must be

remembered that it has contributed to a feeling among those who are or have been associated with the Contingent which will hinder the future work of the O.T.C. unless a better basis of co-operation between the War Office and the Universities can be established.

Position of Officers.

The position of officers of the Contingent on mobilisation and during the War deserves special consideration. No orders or instructions were issued to officers by the War Office at the outbreak of War, and pay and allowances were not granted except by special arrangement. It was left to the private judgment of individual officers to decide whether and when to transfer to combatant units. In order to obtain employment in mobilised units, a suitable unit had to be found by the officer's unaided efforts. This almost invariably involved loss of seniority, and, in several instances, loss of rank. A few examples may be quoted. To an officer who had held the rank of Captain in the Contingent since 1909 and had seen active service in the South African War, were assigned the duties of Lieutenant on commencing active combatant service in France in November, 1914, at the same time that to Second Lieutenants of the Special Reserve were assigned the duties of Captain; the only possible reason for this discrimination being that the status of O.T.C. officers was not recognised. Another officer, who had held the rank of Captain in the contingent since 1911, lost seniority on going on active service and has received no promotion during the War. Others who held the rank of Lieutenant went on active service in the rank of Second Lieutenant. It may fairly be said that these and other officers of the Contingent, having devoted some years to the training of cadets for commissions and being usually University teachers or graduates, were exceptionally well qualified for responsible military work in the War. Officers who remained with the Contingent and have been employed in training cadets for commissions are still in doubt whether they are regarded officially as having served in the War. It should be noted that the position of officers of the Senior Division of the O.T.C. on embodiment is laid down in para. 11 of the O.T.C. Regulations as follows:—"Officers will have, as individuals, the same liabilities for service as other officers of the Special Reserve or the Territorial Force, as the case may be; their services on embodiment will be at the disposal of the Army Council." It is believed, however, that no O.T.C. officer whether he transferred to an embodied unit or remained with his Contingent has received the £5 gratuity granted to Territorial Force Officers on embodiment. The conditions to which officers of the Contingent have been subject during the War have been such that several of the officers who have left the Contingent for active service have refused to rejoin the Contingent unless these conditions are modified and the status of O.T.C. officers is improved.

Position on Outbreak of War.

The efficiency of the work of the University of London O.T.C. during the War undoubtedly suffered from the fact that no War policy was worked out before the outbreak of War. Whereas every other branch of the Army was mobilised, the Senior Division of the O.T.C. was not mobilised and was not provided with any definite scheme of work or given any special assistance by the War Office. Rumours were current that the Contingents were to be disbanded. As a fact the Contingent found itself confronted with a plethora of good material desiring training for commissions. Graduates and past and present students came forward in large numbers, both from home and abroad. Some of these were obliged to join mobilised units for the reasons discussed below. Various arrangements for training were improvised, including the establishment of a full-time training school at Perivale, near Ealing. The system of full-time training initiated in August, 1914, was carried on without interruption until after the Armistice. The work was hampered, however, by changes of *personnel* among the officers owing to officers leaving for active service. The Regular Adjutant left at the outbreak of War and was never replaced by the War Office during the War, an Acting Adjutant having been appointed regimentally. The work of the Contingent was carried on throughout the War practically without any supervision or inspection.

Position of Cadets.

Cadets of the O.T.C. have no liability for service and are not required to take the oath of allegiance. Pay and allowances were, therefore, not issued during the War, even when cadets were undergoing full-time training. In consequence, there was a loss of valuable material which the Contingent could have trained. Graduates and students of the University unable to maintain themselves without pay were obliged to join mobilised units such as the University and Public Schools Battalion, the Inns of Court O.T.C. and the Artists Rifles. Throughout the War no grants were given for annual training in camp in the case of combatant units, although the ordinary grants were allowed for the camps of the Medical Unit. Engineer and Infantry cadets were, therefore, required to pay for their rations in camp. Many of these cadets had put in long periods of full-time training and borne all the personal expenses of their training except as regards uniform. In a number of cases these cadets were killed in action within a few weeks of attending the O.T.C.

camp. It may be noted that cadets at Sandhurst and Woolwich were exempted from payment of fees during the War.

When compulsory service was introduced early in 1916 and the system of training cadets in officer cadet units was set up, the Contingent was deprived of the privilege of providing the complete training for commissions which had been exercised since the the original establishment of the O.T.C. Cadets on attaining military age had to apply for exemption from military service. Cadets remained in the University O.T.C. until attaining the age of about 18½, when they were transferred to officer cadet units to undergo training which in many respects was a repetition of training already received in the O.T.C. Although allowed to remain in the O.T.C. until attaining the age of 18½, at a time when the age for compulsory service was 18 years, cadets were to a great extent deprived of the advantages of University education because under Army Council Instruction (No. 409 of 1917, dated 7th March, 1917) cadets were required to undergo full-time military training from the age of 17 years 9 months. Cadets during this period were not given the status of soldiers even while obliged to undergo full-time military training.

Throughout the War O.T.C. cadets had the legal status of civilians and suffered various disabilities in consequence, e.g., as regards pay, travelling, wearing of uniforms, rations, etc. As an illustration, the position of cadets as regards educational grants may be quoted. In the House of Commons on June 30th, 1919, Sir Robert Woods asked the Secretary of State for War whether attested cadets of the Dublin University and Belfast University Officers Training Corps were ineligible for the Government scheme of educational grants, while those of the Inns of Court and Artists Rifles were so eligible; and, if so, what was the reason for the distinction, in view of the fact that the conditions of service were the same, except that the English contingents received pay, while the Irish defrayed their own expenses? Mr. Churchill replied that members of the Inns of Court and Artists Rifles Officers Training Corps were fully enlisted private soldiers, liable for service under the Military Service Acts, and in exactly the same position as any soldier in any unit at home or overseas. They were paid as soldiers and could be drafted wherever the Army Council thought best. The University (Senior) Contingents of the Officers Training Corps were composed of volunteers, not liable for service under the Military Service Acts. The University cadets were not paid, and the Army Council had no power to order them where they chose. He admitted that in Ireland these volunteers were formally attested, but stated that there was no substantial difference between them and the cadets of English University Contingents.

It cannot be too strongly emphasised that during the War, with few exceptions, cadets of the University of London O.T.C. applied for commissions as soon as qualified, and in many cases voluntarily accepted in the earlier months of the War a wider liability for service than the Territorial officer or soldier. The statistics quoted above prove this. Any distinction between the Senior Division of the O.T.C. and a Territorial Unit based on liability for service is, therefore, to a great extent artificial.

Relations with Junior Division of the O.T.C.

Experience both before and during the War has shown that certain advantages have resulted from the relations established between the Senior Division of the O.T.C., composed of University contingents, and the Junior Division, composed of public school contingents. A considerable number of cadets have passed from the Junior to the Senior Division having already gained Certificate A, and their training in the Senior Division has been adapted accordingly. There are, however, in London a number of large secondary schools which have no contingents of the Officers Training Corps but have, nevertheless, supplied a number of cadets to the University of London O.T.C. Some of these schools have recognised Cadet Corps which provide military training not widely dissimilar from the training provided in junior contingents of the Officers Training Corps. The University O.T.C. should be able to establish relations with such school cadet corps as may appear desirable as well as with the Junior O.T.C's within the area.

It is most desirable that the Officers Training Corps should enjoy the status of an organisation discharging important responsibilities. From this point of view, the fact that public school boys of 13 and 14 are, under existing regulations, enrolled as cadets of the Officers Training Corps is much to be deprecated, as suggesting to the public that the O.T.C. is akin to the Boy Scouts. The status of cadets of the Officer Training Corps should only be given to boys of an age and development which would enable them to bear arms and undergo serious training with a view to commissions in the Army.

Recommendations.

1. The Senior Division of the Officers Training Corps, composed of contingents provided by Universities, should be organised as a distinct Corps entitled the Officers Training Corps. Except in special circumstances, commissions in the Regular Army (University Commissions), Special Reserve and Territorial Force should be granted only to persons who have received training provided in the Officers Training Corps or equivalent training. The present Junior Division of the Officers Training Corps should not form part of such Corps but should be given a distinct name and organisation. The officers and

some of the non-commissioned officers of each Contingent of the Officers Training Corps should form a cadre unit (or units) of the Territorial Force with its own precedence and seniority, and Military Education Committees of Universities should exercise the functions of Territorial Associations in respect of such units.

2. On the outbreak of War necessitating the embodiment of the Territorial Force the Officers Training Corps should be similarly embodied and its organisation expanded and adapted to train officers for the augmented establishments during War and to replace casualties. Contingents should keep in touch with former cadets, should ascertain their willingness to come forward for commissions in a national emergency, and should be empowered to recommend such former cadets for commissions.

3. In peace time grants should be made by the War Office to Universities to cover all approved expenses incurred by cadets while undergoing training in the Officers Training Corps.

4. Provision should be made in the Officers Training Corps for all branches of specialised military work, particularly those involving the application of science to war.

5. Provision should be made by the War Office for giving facilities for suitable soldiers selected from the ranks of the Regular Army to pursue a course of study in the University and to undergo military training in the University Contingents of the Officers Training Corps with a view to qualifying for commissions in the Regular Army.

EDWARD H. BUSK,
Chairman.

46, Russell Square, London, W.C.1.
October 15th, 1919.

Correspondence.

To the Editor of GUY'S HOSPITAL GAZETTE.

[We would point out that we cannot *in any circumstances* publish any letter unaccompanied by the writer's name and address, not necessarily for publication.—ED., G.H.G.]

DEAR SIR,—The publication of two cases of anaphylactic shock in the GAZETTE for November 15th and December 13th induces me to send you a few remarks on the subject.

In the first place each of the reporters of the cases draws attention to what they believe to be their rarity. I doubt, however, whether they are so rare as your reporters think. Relatively to the huge number of injections and re-injections of serum that must have been given to the sick and wounded during the war perhaps they are rare, but I have reason for thinking that absolutely they are not uncommon. For two years and a-half ending July last I was in charge of a large military hospital, and during that period I saw eight cases of anaphylaxis in four of which there was severe shock. None of these cases have been reported, and, as I cannot believe that my experience is unique, I am led to conclude that cases have occurred in military hospitals both at home and abroad which have likewise gone unreported if not also unrecorded. I do not think that I should have got to know of all the cases to which I refer if it had not been known to my medical staff that anaphylaxis was a subject in which I was particularly interested.

Secondly, of the cases published in the GAZETTE one was an example of acquired, the other of natural anaphylaxis (the case reported by "A.N.C."). The latter are usually the most severe; a fatal case was reported in the *British Medical Journal* for November 8th last. In this case serum had been injected as a prophylactic against diphtheria.

Thirdly, asthmatics are specially prone to furnish subjects of natural anaphylaxis. Such was "A.N.C."s case. In a memorandum on the use of curative sera issued by the Medical Department of the War Office in the summer of 1917, special attention is drawn to the necessity of inquiring whether the patient is particularly sensitive to horses.

Fourthly, "A.N.C." asks whether a serum from some other animal than a horse would have precipitated the same alarming symptoms. The answer to this question is that it would not have done so, unless from some animal nearly related to the horse, such as the ass. The serum of an ox, for example, would not have been noxious. This has been proved by experiments on animals.

Should any of your readers wish for further information on the clinical aspect of this subject, I would refer him to a paper I published concerning it in *The Lancet*, vol. i, 1918.—I am, yours faithfully,

E. W. GOODALL.

North Western Hospital,
Hampstead, N.W.3.
December 14th, 1919.

Medical Research.

DEAR SIR,—I am indeed glad that my letter to you on this subject has drawn from my old friend and house physician, Dr. Gordon Goodhart, such a thoughtful contribution to our discussion. His views are so well expressed and so much to my liking that

I am inclined to leave well alone and merely to say that I entirely agree that research (with a small "r") has always been and always will be the life-blood of Guy's. It gives me a shudder when I hear of *a* research ward being established here, which would seem to imply that in the future research would not be a necessary feature of every ward. If anything I said in my last letter left this position in doubt I am obliged to Dr. Goodhart for helping to clear it up.

I am interested in Dr. Goodhart's use of the word inquisitiveness to denote our childish inclination to observe and speculate. I wonder when this valuable faculty came to be regarded as a vice instead of a virtue. Certainly the word inquisitive has now a deleterious flavour about it. One can imagine a child with the normal enquiring turn of mind wondering whether it would be *inquisitive* to ask why the lid of the boiling kettle is popping up and down and coming to the conclusion that if it would be it would be something closely akin to naughtiness. Mr. Wells in his "Outline of History" says it is because we have been too busy killing each other and making money that we have failed to be sufficiently inquisitive to study the record of the rocks, but I am not sure that it is not because we have been trained to regard inquisitiveness as vicious or at least non-virtuous. I expect this is why the most difficult of all my tasks as a clinical teacher was to encourage my ward clerks to ask questions. They always preferred to leave the question asking to me. They thus at least avoided the risk of being accused of inquisitiveness.

Quite indirectly Dr. Gordon Goodhart's letter raises another point in medical education which is of great importance. He uses the term "undergraduate medical school." If I feel constrained to protest with all my power against a division of our wards into re earch and non-research wards I should pray for even greater strength to protest against a division of our schools into undergraduate and graduate schools. Such a protest seems to be timely, for I notice in the lay and medical press indications that there is a movement in this direction. As a mere emergency measure to deal with an acute post-war condition it may be necessary to set up separate institutions to deal with a large influx of post-graduate students. But this should be regarded as a purely temporary measure, and even so should not entail the cessation for a moment of the fullest and highest development of post-graduate education and research in all the ordinary medical schools. An "undergraduate medical school" is as complete an anomaly as a non-research ward at Guy's. I am sure Dr. Goodhart is as innocent of tolerating the one as I am of the other.—I am, yours sincerely,

LAURISTON E. SHAW.

December 20th, 1919.

DEAR SIR,—Having had cause to visit the Hospital during the last week, I was surprised and pained to find crude and somewhat blatant advertisements plastered about the colonnade and park. "Manus juste nardus"—therefore in all fairness I purchased a copy of the periodical so advertised. The journal exceeded my worst premonitions, and showed an utter lack of taste in its vulgar and unkind criticisms. I cannot but think that our superintendent, so soon to leave us, must be deeply hurt by its unseemly jibes, and I venture to suggest that disciplinary methods should be adopted against those responsible for this outrage.—Yours faithfully,

NEMO.

Reviews, etc.

Books for review should be addressed to The Editor, Gazette Office, Guy's Hospital, S.E. Their price should in every case be stated.

Post-Mortem Manual. By Chas. R. Box, M.D., B.S., B.Sc., F.R.C.P., F.R.C.S. (Messrs. J. & A. Churchill, pp. 351, price 8s. 6d. net).

A second edition of this excellent manual has appeared, and the whole book has been thoroughly revised. Several additions have been made, notably instructions for obtaining material for bacteriological and other examinations. This book should prove invaluable both to the qualified and unqualified student of medicine. The instructions given are both clear and precise, while the short descriptions of morbid anatomy given at the end of each chapter supply a long-felt need of the student going up for his final examinations, who so often has specimens innumerable at his disposal but has nothing to guide his untrained, if eager, observation.

An Atlas of Dental Extractions. By C. E. Wallis. (Messrs. J. & A. Churchill) 23 pages, 6 illustrations, and 11 double page plates. 2nd edition. 5s. net.

This small volume has been designed solely for the use of *medical* students and practitioners, to enable them to perform dental operations if the services of a dental surgeon are not obtainable, and is not intended to be a Manual of Dental Surgery. The author commences with a brief description of the most frequent causes of dental pain, and suggests various simple methods of treatment. He then gives eleven excellent plates, illustrating the methods to adopt in extracting teeth from the different situations in the mouth, and also the instruments to be adopted in the case of each tooth. To *medical* students, (whose

knowledge of dentistry is usually very limited, this atlas should prove very useful, and we think it is worthy of a place on their bookshelves.

A Handbook of Anæsthetics. By J. Stuart Ross. (Messrs. E. & S. Livingstone.) 207 pages, 54 illustrations.

Most people, we think, are agreed on the point that the only way to learn the methods of administration of anæsthetics is by practice. Nevertheless it is necessary to have some knowledge of the theory also, and this little handbook will be found very excellent for the purpose. The author starts with a brief account of the physiological action of the anæsthetic drugs. He goes on to the methods of anæsthetising and the preparation of the patient, and then describes the different drugs it is possible to employ and their advantages and disadvantages. The chapter on the "Accidents of Anæsthesia" gives points which should be known but of which one does not care to have too much practical experience. The latest methods of gas and oxygen anæsthesia are given, and the terminal chapters on local and spinal anæsthesia are very helpful. The book is well illustrated, and we can recommend it both to the student and the practitioner.

Sussex in Bygone Days: Reminiscences of Nathaniel Paine Blaker, M.R.C.S. Published by Messrs. Combridges, Hove; pp. 199, price 5s.

Dr. Blaker was born in 1835, and his reminiscences of Sussex life at the time of his youth make very interesting reading not only for lovers of Sussex but also for all who are interested in old customs. He commenced his medical studies at Guy's in 1855, and the latter half of his book is devoted to experiences in his medical career which, dating as they do to pre-Listerian surgery, throw illuminating side-lights on the history of modern medical practice. We must thank Dr. Blaker for a very interesting addition to our library.

Guy's Hospital War Memorial.

Amount already acknowledged	£5,062	5 10
Gibson, F. G.	5	0 0
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Wells, S. M.	5	0 0
Hollands A. C.*	3	0 0
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*Second contribution.

Ellis's Medical Lending Library.

A new medical lending library has been opened at 9, Lovell's Court, Paternoster Row, E.C., where any medical book or number of books may be borrowed at a time by subscribers.

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Notice.

COURSE FOR THE DIPLOMA IN PUBLIC HEALTH.

The Chemistry Section of this Course will commence on Monday the 5th January, 1920, and will extend over the period January-March.

It will be followed by a Course in Bacteriology during April-June.

Students who wish to take the Course in January are requested to leave their names at the Medical School Office not later than Saturday, the 3rd January.

Guy's Hospital,
24th December, 1919.

Football.

GUY'S v. LONDON WELSH.

Played at Honor Oak Park on Saturday, December 13th, and won by two goals to nil; 10 points to nil.

An extraordinary game, and a very hard one. Extraordinary because our opponents seemed annoyed with us when the very opposite should have been

the case. They played remarkably well, and should have been very well pleased that they escaped so lightly. Certainly their forwards for most of the game were in excellent fettle, and did most things except get the ball from the scrum. Our men beat them there. Another pity was that Steyn had something go wrong with his leg, and could take little part in the play. P. Krige was practically without a wingman, and Shaw has two faults; one is he bores his outside by running too diagonally, and frequently punts instead of passing. All the same, he is a greatly improved player, and defends fearlessly. Reitz got the first try quite early in the game, a smart follow up, and Witts, the full-back, failed to gather. Reitz quickly touched down, and Steyn kicked a good goal. The Welsh play was forceful but too hard, and Olivier kept his line intact. Then the Hospital threes tried passing, but Van Nickert was squeezed on the line and Krige badly wanted support. You cannot overlap four three-quarters with three and a crocked man. Marais showed up well, and so did Neser. He should join his brother in the next trial.

The second half was very evenly contested, and once the opposing side looked certan to score till Olivier put Williams down, and a strong dribble by Michael, the Welsh captain, ended in an injury which caused that player to rest. He soon resumed, however. Then Guy's got down again, Bekker working like a Trojan. Several times our men fairly buzzed on the line, till fine passing reached Steyn, who forgot his troubles and scored for Neser to kick a really magnificent goal. Guy's had Doherty, Duncan, Watson and Graham Davies away. The forwards did not follow up enough, Marais, Shellswell and Neser excepted. Even Reitz did not exhibit his usual energy after his try. But there is excuse for men who played in Dublin on Wednesday and only crossed Thursday night. More speed in the pack is necessary. Guy's, 10 points; London Welsh, 0. Guy's team:—

W. Olivier, J. Van Nickert, T. A. Shaw, P. J. Krige, G. L. Steyn, F. Bekker, G. Van Schalkwijk, F. W. Reitz, A. Marais, A. H. Shellswell, E. Neser, G. Zondagh, G. R. Aspinwall, and L. J. Biddle.

GUY'S v. OLD MILLHILLIANS.

On the home ground the Guy's team, with many first fifteen men away, won this match, played Saturday, December 20th, and fittingly was the first half of our season brought to a close with a score of 30 points to three. The points were made up by four goals (two dropped) to four tries. The half-season's total is 296 points to 26. Not bad for a team suppossed to be fallen from its earlier high estate. Doherty, Reitz, Marais, Aspinwall, Steyn, and Graham Davies were away, and P. J. Krige was at Twickenham playing for the South. To-day I hear he did remarkably well, and so did Millett. May both get an English Cap. Millett has been good enough for one for years.

Shaw opened the scoring with a dropped goal, and after Pauw had hoofed the ball much too hard into the full-back's hands, Van Nickert ran in by the corner. A very kind decision on the referee's part. Then Van Schalkwijk, who made an excellent centre—he has more time to get up steam in that position—tried a drop from a penalty. Seward tried another. Strange how catching the habit is. But the frequency with which our threes got moving soon tangled the defence, Shaw scoring. A grand kick by Neser added the points, and later he gained a very neat try and followed it up by a good shot for goal. At the other end McLennan dropped for goal. A great pity for his side. Returning to the Millhill end Van Schalkwijk found himself with time and space right in front of the posts, a rare chance; he seized it and dropped a very pretty goal.

The second half commenced with a good try by Seward. Neser led up to it. The Millhill men now for twenty minutes played good solid football and gained a well-earned try that eveyone was pleased to see. They were good sportsmen and triers all the time. Shaw had a slight attack of his kicking habit, but otherwise he played a fine game and his fielding was splendid. All the backs did well. The ball was not easy to hold. Two or three times Bekker got buried beneath about a dozen forwards, and then passing came right along to Van Nickert, who got over. One would give much even in these times to imbue so good a player with a little more pace. Pauw finished the scoring with a try. Neser kicked another fine goal from Neser's try. A special word of commendation to Olivier; he played grandly with feet and head. Guy's team:—

W. Olivier, E. C. Seward, T. A. Shaw, G. Van Schalkwijk, J. Van Nickert, F. Bekker, E. L. Sprong, A. H. Shellswell, L. K. Watson, E. E. Neser, G. Zondagh, L. J. Biddle, J. Van Zil, B. L. Laver, and A. Pauw.

Seated in the stand one frequently heard W. D. Doherty, the captain, shouting to the forwards. They were terribly late in getting round, also in lining up. The Cup Ties are almost on us. The forwards must train very hard and get in perfect condition. It will not be exactly a picnic. On Saturday, too, the whole team tried to tackle ears or shoulders, an awful pity, quite unnecessary and absolutely the reverse of good play.

ED.—J. V. C. B.